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ABSTRACT

This volume of 12 separate lessons--each written by either a medical or mental health professional--provides expert information on a wide variety of medical and psychological issues in rehabilitative counseling. The lessons, each of which concludes with a few multiple-choice questions, are as follows: (1) "Adaptive Styles in the Etiology of Depression" (Peter C. Whybrow); (2) "Stress in the Workplace" (Gerald A. Kraines); (3) "Women and Alcoholism" (Edward Rabinowitz); (4) "Advances in the Treatment of Anxiety Disorders: A Therapist's Guide" (Robert L. DuPont and Keith E. Saylor); (5) "Rehabilitation Counseling with the Criminal Offender in the Community Setting" (Jay R. Stewart); (6) "Co-Dependence: A New Diagnosis" (Robert L. DuPont and John P. McGovern); (7) "Evaluating the Deaf Client" (John Misiaszek and Jenifer George Misiaszek); (8) "AIDS: Diagnosis, Treatment, and Management" (Robert A. MacGuffie and Karen J. MacGuffie); (9) "Vocational Rehabilitation in Schizophrenia" (Cecile Mackota and H. Richard Lamb); (10) "Private-Sector Rehabilitation" (Ruth Torkelson Lynch and Ross K. Lynch); (11) "Rehabilitation Counseling with Members of Minority Populations" (Paul Leung); and (12) "Improved Detoxification from Drugs and Alcohol through Nutrition" (Jeffrey S. Bland). (Contains an index. Each lesson contains references.) (RJM)

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Directions in Rehabilitation Counseling

VOLUME 3 • LESSON 1

Adaptive Styles in the Etiology of Depression

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VOL. 3, NO. 1

January, 1992

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EDITOR'S NOTE

Understanding the origins of any experience of depression and selecting strategies to deal appropriately with the various ways in which the need to cope with change and loss has evolved over years are essential elements in successful clinical management. In this lesson, the author reviews the salient aspects of attachment and separation from a developmental perspective, stressing the importance of a childhood environment that permits the individual to gradually learn how to tolerate separation, eventually supplement with others the exclusive caring originally provided by parents, and provide one's own needed supports as an adult. The nature of the bonds formed and subsequently modified during childhood is a substructure that supports self-esteem and autonomy in adult life. Self-reliance is not isolation but rather depends on being able to rely trustingly on others, to know on whom to rely and when, and to permit oneself to be relied upon.

Three common maladaptive personality styles that stem from a failure to master the attachment-separation experience early in life are described: dependence on a dominant person, excessive control, and pseudoindependence. Each in its own way is an attempt to avoid the pain of loss or rejection and, although initially it can represent a successful form of coping, eventually it creates a special vulnerability to depression. In treatment, due attention must be paid to dealing with these unhealthy adjustment patterns.

Introduction

Psychological mechanisms play a significant role in both the genesis and resolution of depression. Although psychodynamic factors may appear more apparent in so-called reactive depressions—those in which events of a specific and identifiable nature appear related to the onset of the episode of dysphoric mood—they cannot be ignored even in the treatment of those whose symptoms are primarily of the melancholic type and in whom clear-cut precipitating causes may not be obvious. Whether the goals of treatment are limited and supportive or intensive and aimed at fundamental characterological changes, the psychological management of the depressed client requires a careful understanding of maladaptive behavior patterns that have set the stage for illness and may retard recovery.

It is generally accepted that a significant loss, frequently highly personalized, is commonly a cause for depression, particularly when such trauma involves a diminution of self-esteem. However, **the manner in which a particular client has tended to cope with various losses over the years—the mode of adaptation can take a number of different forms, each of which calls for an appropriate therapeutic strategy.** To understand these styles, it seems logical to review, briefly, the close relationship between the quality of human attachments on the one hand and vulnerability to depression and loss of self-esteem on the other.

Normal Adaptation and the Development of Autonomy

All living creatures maintain a relative autonomy from their environment. This is implemented by adaptation. In this regard human beings do not differ from other organisms except that they are more complex.

Adaptation is essentially the appropriate response of the organism to an environmental challenge, whether it be an invading micro-organism or a perceived psychic assault. **When the individual can adapt with some degree of success, this phenomenon is called coping.** From the perspective of practical psychobiology, **we may view human depression as a temporary failure to adapt successfully**a state in which the individual is transiently overwhelmed by diverse challenge. **This is not necessarily pathological. In fact, it is the disruption and learned adaptations to various challenges early in life that makes later coping possible.** Exposure to infectious agents builds immunity. The complex dendritic structure of the cerebellum grows more complex under the challenge of learning how to walk. Innate ability is no less important than the quality of environmental events in this process of growth. However, acquisition of coping ability is facilitated by consistency in environmental challenge. Thus an environment that is capricious, punitive, unpredictable, overprotective, or inadequate in its challenge will usually result in restricted styles of personality coping.

For the growing child, as for the adult, change is an everyday occurrence. One of the central issues in childhood involves the experience of separation and loss. As the child learns how to successfully master these, autonomy and an objective regard of self is also built. Feelings of helplessness and even hopelessness are integral parts of this development. Engel has called these **"signal functions"—warnings to permit the anticipation of special traumas that have been experienced previously and now threaten to overwhelm the individual unless successful adaptation is achieved.**

The Role of Attachment and Separation

The significance of attachments in the formation of self-esteem and autonomy is not unique to human beings. In primates, for example, the reaction to separation is clearly defined. Close attachment between parent and offspring and, later, between peers is the developmental mode in primates. Once such attachment is formed, disruption causes a stage of protest and subsequently, withdrawal, involving both a psychological detachment and a somatic withdrawal.

A similar syndrome, response to separation from the caring parent has been the object of considerable study in human infants. Attention was first specifically drawn to this phenomenon by Spitz who focused largely on **the withdrawal phase and termed it anaclitic depression.** Later, Bowlby's studies and those of others made it apparent that **the reaction to separation follows a typical pattern, best understood in sequence and essentially as follows:**

During the first year of life, the child begins to form specific attachment to the person who provides most of his or her care, as well as to the environment in which that care takes place. Most importantly, through the central nervous system, an awareness develops of the special association between subjective comfort and events that occur. Thus, **in a strange environment and particularly in the presence of a stranger, the infant protests initially, then becomes tense and cries out. If the preferred person does not return, the protest continues, but after a while it merges into what appears to be a despairing detachment.** Engel called this **conservation-withdrawal,** citing the example of the infant Monica who had been fed through a gastric fistula with minimal nurturing because of her mother's depression.

When her protest was exhausted, a phase of conservation-withdrawal became dominant--a passive, sleeplike state associated with virtually no motor activity and cessation of gastric secretion.

Such withdrawal appears to be an adaptive response to a depriving environment. It is an experience that is, to some degree, unavoidable in the life of any infant or child. In fact if not too severe, traumatic or prolonged, it is invaluable as a developemental challenge. As the child grows, the biological state becomes associated with subjective feelings of helplessness, to which feelings of hopelessness may be added later as the person consciously recognizes the inadequacy of his or her capacity to respond. **This basic psychosomatic process stands in sharp contrast to the active-engaging posture that the growing infant adopts when secure in an environment perceived as nurturing.**

In humans, the basic psychobiological process of attachment and separation is significantly modified by abstract conceptual thought. Our ability to adapt to and modify our environment in our own interest is a function of our particularly complex and vigilant nervous system that integrates and modulates every detail of our response. **As we grow we learn to tolerate separation and to supplement with others the exclusive caring originally provided by parents. Eventually, we provide our own needed supports** and set standards that are both internal and specific to ourselves.

Self-esteem and Competence

Self-esteem is a healthy respect for one's abilities and appreciation of one's limitations. Its regulation is perhaps one of the most complicated mechanisms in human psychology. There is no single road to a sense of mastery. Throughout life, we strive

for autonomy and discover, in the process, ingenious ways to cope. Based on past experiences, we form ideals against which to measure achievement, and self-esteem becomes, in large part, a function of the extent to which individuals believe they can and do live up to the goals they have set for themselves. From a developmental point of view, it is critical to remember that **the sub-structure that supports self-esteem, ego ideals, and autonomy in adult life derives from the nature of the bonds that were developed and subsequently modified during the individual's childhood in relationships with members of his or her primary family.**

As Bowlby pointed out: "When an individual is confident that an attachment figure will be available to him when he deserves it, that person will be much less prone to either intense or chronic fear than will be an individual who for any reason has no such confidence.

"Confidence in the accessibility and responsiveness to attachment figures, or lack of it, is built up slowly during all the years of immaturity; and once developed, these expectations tend to persist relatively unchanged throughout life."

Self-reliance is not, therefore, the cultural stereotype of needing no one. Rather it is the ability to rely trustingly on others, to know on whom to rely and when, and to permit oneself to be relied upon.

Grief

Over a period of years, one's sense of self and of reality evolves, as one builds an analogue of the perceived world and then embellishes it. This becomes a private

template for adaptation and the maintenance of autonomy, serving to help us cope with the changes and losses that life inevitably provides, such as leaving home, illness, romantic and sexual attachment and loss, marriage, divorce, children, and the death of those close to us. **When we falter at times in these adaptations, it is natural to reexperience to some degree the helplessness and hopelessness that we experienced as children faced with situations that seemed to be more than we could cope with at the time. Such subjective feelings are reported as depression.** The healthy person recognizes them, understands them, struggles with them, and eventually recovers by means of his or her own adaptive modes.

Many of these features are seen in the normal experience of grief—the reaction that follows the death or loss of someone with whom one has enjoyed a close emotional bond. The stages in the process of grief resemble those seen in depression. **The initial reaction is disbelief or protest. Somatic distress and a preoccupation with the image of the dead person go hand in hand. Subsequently there may be a transient loss of the usual patterns in which we conduct our lives, with some withdrawal and guilty speculation on what contribution we have made to the person's death or unhappiness during his or her lifetime.** However, **even though these disturbances seem indistinguishable from depressive illness at times, most people accept the experience in themselves or in their friends and relatives as quite normal, providing the person recovers from the impact in a reasonable period of time** and does not enter a serious psychiatric disorder.

Maladaptive Personality Styles and Depression

Vulnerability to depressive illness seems to be increased in persons who, for whatever reason, have never satisfactorily resolved the psychobiological

issues surrounding attachment and separation. Such persons remain extremely sensitive to loss—or perceived loss—whether of people, animals, their own career goals, philosophical aspirations, friendships, or material things. **Frequently, in defending against this contingency and its associated feelings of helplessness and hopelessness, such persons have acquired adaptive styles that are meant to aid them in coping but are, in fact, often setting them up to exchange a more normal period of grief for a serious episode of illness. The common denominator among these styles is rigidity.** Some of the mechanisms—or rescue operations—may work quite well for years, but at some point, often in middle age, a special combination of events may disrupt the precarious equilibrium and with it, their self-esteem.

I have found it useful to cluster such adaptative types into three major, though somewhat overlapping, categories:

1. **Dependence on a Dominant Person.** Here, **the basic rescue strategy has been to transfer the unresolved issues surrounding attachment and separation from the parenting figures to others in the subject's life who appear competent and capable. Thus no true self-reliance develops** during the maturing years and the person enters adult life with a constricted series of adaptive options.

Such persons find it difficult to enter the usual commerce of adult life, since **their own self-esteem is tied too closely to the opinions of those around them.** This does not mean that adaptation is impossible; in fact, it is sometimes quite successful for a long time. The key to their adequate psychosocial function, however, is

dependence on some dominant figure who maintains a caretaker's role.

Traditionally, this form of working adaptation has been seen more commonly among women in our culture, possibly in part because it has been considered acceptable, perhaps even desirable, for women to be dependent on a dominant male figure. Often such women married early, moved away from the primary family, and spent considerable energy in the new relationship tying to please the person on whom they depended for their self-worth. If the husband reciprocated with kindness and support, this kind of balance could continue for years, and was usually threatened when their role as mother diminished as their children grew up and left home. More recently, however, it has been recognized that **men can just as readily form such dependent attachments on women,** leaving their primary homes without adequate autonomy and looking to their lovers or wives for parental support.

Such an adaptation can function, more or less, until either the dominant figure in the person's life disrupts the primary bond, either by cruelty, desertion, infidelity, death, or some other inter-current event. **Unfortunately, such persons frequently form a liaison with those who are themselves struggling to ward off the pain of attachment-separation problems by means of pseudoindependence,** a style described later on, and who themselves have a need for support but have, by one means or another, been able to rely on their own abilities exclusively early in their adult lives. Frequently, in such a marriage, as the man becomes increasingly engaged in a professional role he is not longer able or willing to nurture his dependent wife; as a woman devotes more of her time to children or her own pursuits, her dependent husband feels abandoned.

Under such circumstances, the adaptive style starts to crack. The dedication and investment in the affairs of the family or the other bring diminishing rewards. **With one partner or the other becoming increasingly remote, the vulnerable person feels a sense of growing helplessness and hopelessness** that is identified as depression and that may well progress to severe illness. Anger erupts—something that has been there for a long time and is basically driven by a person's sense of never having been truly provided for or cared about, either in the primary family or within the present relationship. Withdrawal and serious depression may ensue.

2. **Excessive Control.** When there is an inconsistency in the available caring figures during the maturational years, a potential adaptation in adolescence and early adult life is to **reduce to a minimum the number of situations in which the difficult task of resolving separation anxiety is likely to occur. The need to control the day-to-day details of life becomes a primary mechanism of adaptation. Basic to this strategy is the restriction of novelty and the unexpected.** Planning assumes great importance. Surprises are often greeted with a hostile response. In such a character structure there is little spontaneity; instead, meticulousness and reliability are developed to an extreme. **Because these obsessive styles are highly marketable and well rewarded, such people do fairly well early in life.**

This adaptation is usually seen as a psychological rescue attempt in an individual who has had **little opportunity to develop a fundamental trust in others.** It serves to compensate for an inadequate resolution of the attachment-separation paradigm. **When the adaptive style is threatened by an increased number of events that the person can no longer keep under control, the underlying lack**

of trust rapidly appears. Overt suspiciousness and even paranoia may emerge, covering up the intense sense of helplessness that such persons usually feel. This, in turn, only isolates them even further from human contact.

Even when the strategy of control is working, **such persons find difficulty in delegating authority to others.** It is not uncommon for the very work habits that permit them to rise through organization ranks or in professions to become serious handicaps when positions of real authority and leadership are reached. Gradually they fail as they become unable to control the steadily increasing number of variables with which they have to deal. Aging, illness, and other life problems that reduce the ability to remain in control shake the foundation of this defense against the pain of loss, leading to depression.

3. **Pseudoindependence.** This method of adaptation is closely allied with that of maintaining excessive control. Again the individual avoids close contact with others and thereby reduces the opportunities for loss. To all outward appearance, such persons appear independent, competent, with high aspirations for themselves and others. They may believe in a well-structured philosophy based on social or religious beliefs. They may enjoy serving others and usually do it well. Hence they are often valuable members of their communities.

However, **they often have broken away from their primary family early in life, setting up, by effort and hard work, an independent life of their own. Instinctively, they make others dependent on them,** perhaps thereby gaining vicarious gratification, clearly feeling safer under such circumstances.

On the other hand, **not far beneath the surface and usually within their awareness, they often yearn for a close relationship with a caring person**--someone who fits the very ego ideal for which they themselves reach. **Not infrequently, such persons marry each other and create a life together characterized by remoteness on an emotional level.** Here again, illness, aging, the departure of those who have been dependent on them—such as children growing up and leaving—represent special threats to their ability to cope. **Because they are fearful of being dependent, they often resist seeking help until there is not choice left, and consulting a professional can represent an occasion of intense fear, even panic. In therapy, they are frequently resistant to complying with antidepressant medication if recommended, feeling further compromised in their effort to maintain independence.**

Adaptive Styles and Therapy

The particular styles that the client has assumed during his or her lifetime to deal with disturbed attachment-separation issues and protect against the impact of depression **will reflect themselves in the relationship that is formed with the clinician and in the attitude the client has in approaching treatment.** The professional must carefully **note the emergence of such factors as early as possible** in his or her contact with the client. Sometimes, as in the case of the individual who has sought the protection of depending on a dominant other, finding an understanding and empathetic professional serves to restore a sense of security and worth, catalysing recovery. There is, in some instances, **a risk that the client will become too dependent on the clinician and unable to maintain improvement when the**

end of the therapeutic relationship is in sight. The clinician must give the client the support needed early on, but simultaneously work to cultivate a greater degree of self-reliance as therapy progresses.

The distrustful severely controled client can be particularly problematic. This individual is often **reluctant to open up and communicate spontaneously with the clinician for fear of losing further control. Compliance with medication regimens is commonly difficult to obtain.** There will be times in the course of sessions when **the clinician's patience may be tried by perceived power struggles between the client and himself or herself , but what actually represents the client's attempt to regain control over every aspect of his own life. Symptomatic relief, with antidepressants, often permits the client to function more efficiently again and thus alleviates the distress and heightened need for control** that derives from the strong sense of helplessness. However, since the goals that such clients set for themselves are usually unattainable, **one of the major tasks in treatment is to help them accept the impossibility of their obsessive style and learn how to feel comfortable with uncertainty, ambiguity, and risk and how to gradually place greater trust in others worthy of it.**

For clients whose style has been one of pseudoindependence, one of the main challenges in treatment is to help them **accept whatever limitations life has forced on them and to learn how to permit themselves to rely on others.**

Issues around attachment and separation, loss and its resolution, are obviously not the only way in which depression emerges. Many other factors, both social and biological, conspire with intrapsychic mechanisms to precipitate the final common

path of dysfunction. Such dysfunction itself, however can represent for depressed clients a unique pathway to growth and a singular opportunity to learn new and better adaptive styles. Once the immediate, disorganizing elements in depression have been relieved, clients have an excellent opportunity to work with the clinician to rethink some of the rescue mechanisms that they have developed automatically in earlier years. While many of these may have served them well, aspects of them have clearly done them disservice, and this is the time to acquire additional ones, particularly the flexibility that will allow them to cope more effectively with challenges in their present and future lives.

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QUESTIONS BASED ON THIS LESSON:

1. Which of the following statements is correct?
   A. Bowlby described the nature of "signal functions"
   B. The initial response of the infant exposed to strange circumstances is marked withdrawal
   C. Infant withdrawal is an adaptive response to excessive stimulation
   D. In humans, the basic psychobiological process of attachment-separation is modified by abstract conceptual thought

2. Self-esteem, ego ideals, and autonomy are:
   A. Significantly derived from bonds with primary family members
   B. Best attained by complete freedom from dependency needs
   C. Dependent on denying one's limitations
   D. All of the above

3. The common denominator among various maladaptive styles to minimize the impact of loss is:
   A. Obsessive-compulsive traits
   B. Indecisiveness
   C. Rigidity
   D. Paranoid tendencies

4. According to the author, the person dependent on the dominant-other often marries someone who is:

   A. Chronically depressed

   B. Similarly dependent

   C. Pseudoindependent

   D. Excessively controlling

Directions in Rehabilitation Counseling

VOLUME 3 • LESSON 2

Stress in the Workplace

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VOL. 3, NO. 2

February, 1992

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EDITOR'S NOTE

The biopsychosocial model of assessing and treating a wide variety of emotional disorders is generally accepted among rehabilitation counselors. However, while much attention is paid to intrapsychic dynamics, using appropriate psychopharmacologic treatments, and family function, not much is given to the conditions under which the client works. Yet most of our waking hours are spent working. In this lesson, the author presents several models to evaluate interactions between employees and organizations. These psychodynamic, interpersonal, and adaptational models are familiar to most counselors, but their application here to work environments is both novel and useful.

Taking a close look at the nature of any client's working conditions and how it may contribute to dysfunctionality—or how it may represent a special asset to aid recovery—should be an essential part of every evaluation. Some people may be chronically unhappy for having chosen career paths for which they are not well suited. Others may be caught in transference reactions to superiors and peers. Still others may be involved in working environments inherently destructive to self-esteem.

Counselors in group practices and those working within institutions have special responsibilities to provide healthy work conditions. Special attention should be paid to those times when organizations change goals or direction, since preparation of employees is critical to successful transition.

Introduction

The mental health field has always maintained a relative distance from the world of work and organizations. **The training mental health care workers undergo ill-prepares them to understand the role that work plays in the development of self-esteem[1] and identity, the nature of the relationship between individuals and organizations, and the dynamic effects of constantly changing work realities on the individuals who must respond to them. Rehabilitation counselors, on the other hand, must understand the relationship between work and the well-being of the individual.**

This lesson will not present a new "psychology of work." Instead, it will summarize the efforts of Harry Levinson[2,3] and his associates during the past 35 years to adapt existing psychological constructs to work-related interactions. The clinicians in the Levinson Institute forged these refinements of current psychological theories out in the field—studying, teaching, and serving as consultants to industrial leaders and managers. **The models presented here have proved useful diagnostically, heuristically, for purposes of primary prevention, organizational diagnosis[4], and planning, and for clinical interventions.** The psychotherapeutic approaches offered are biased towards rational-cognitive therapies, which assume people in distress need first to know what they are up against.

Three different models—psychodynamic, interpersonal, and adaptive—are addressed in this lesson to explain the effects of the work environment on human functioning.[3] In each approach, **stress is viewed as a by-product of an individual's frustrated and unsuccessful attempts to achieve or recover a sense of personal**

equilibrium.[5] A central task for the clinician is to examine the client's complaints through each of these lenses in order to see which one offers the most useful information to account for the current "pain" or dysfunction and which models make the most sense to the client. We need to differentiate and identify the various sources of stress in order to understand, predict, and reduce their impact on the client.

Psychodynamic Model

Clinicians need to account for **how and why people make their career and job choices and what motivates people to work hard or to resist working.** By using the psychoanalytic constructs of innate drives, dependency, and ego ideal and self-esteem we can address these issues.

DRIVES:

All personality theories assume the existence of instinctual drive states that propel individuals into the world and govern the degree to which they interact with it. **Psychoanalytic theory with its Darwinian origins proposes the basic intrinsic drives are sex and aggression. The vectors of those drives are the constructive energies (love, affection, self-esteem) and the destructive energies (rage, anger, hate). The mature, task-driven individual learns to fuse and harness the energies** from those drives, and the product of their fusion is accomplishment, mastery, and satisfaction.[2,6]

People develop defensive strategies[7] in order to cope with those innate drives and with their family's and the culture's attitudes about those drives. For example, characterizations of the southern European or Mediterranean culture's effusive emotionality

reflect its open, expansive attitude toward both affection and aggression. By contrast, references to the Anglo-Saxon culture's reserved and modest emotional expression reflect a more repressed, constrained, and sublimating attitude.

In general, people with a predominant need for giving affection—those with a style of nurturing others—may choose careers in nursing or social work. Others geared more toward receiving affection and recognition may choose the performing arts or advertising. Conversely, individuals with strong aggressive instincts, with powerful needs for control, may choose engineering, accounting, or coaching. Somewhat more outwardly aggressive individuals may pursue careers in sales and entrepreneurial endeavors. Examples of more overtly instrumental or attacking careers are trial law and military drill instruction. The important point is recognition of the predominant drive state in a client's personality and the coping strategies he or she deploys to contend with those drives. Such inferences yield useful information about the context of the person's pain or stress: who is this person and how did he or she get there?

DEPENDENCY:

All creatures at birth are helpless, dependent on others, and forced to come to terms with significant dependence during childhood and adolescence. Conflicts about trust, autonomy, and guilt are inevitable, and resolution of those conflicts determines an individual's subsequent attitudes on dependency and authority relationships and manifest themselves in the world of work. Healthy adult relationships in organizations require an interdependence that presumes trust in each other's motives and that reduces the guilt of needing support.[8] When unresolved conflicts hinder that healthy interdependence, the full continuum of defense mechanisms[7] may be

exhibited in the workplace (especially in the form of projection, displacement, and passive-aggressive and acting-out behaviors). Thus, predictably, we see some transference of parental attributes by the employee onto his or her superior or organization. By projecting those intentions and traits into power figures at work, subordinates then react to them in ways that recapitulate their own nuclear family behavioral patterns. Dynamics such as parental splitting (the white-hat CEO v. the black-hat operations director), scapegoating (blaming the older "rigid" employee for being unable to change), and sibling rivalry (peers competing with each other for recognition) all manifest themselves in organizations.

EGO IDEAL AND SELF-ESTEEM:

The ego ideal refers to the values, qualities, traits, goals, and styles we observed in adults and sought to emulate during our formative years. If we are to feel good about ourselves and avoid feelings of inadequacy and guilt, we feel compelled to live up to that unconsciously internalized prescription of idealized attributes. At any time, our self-esteem is inversely proportional to the size of the gap between our ego ideal and our self-image.[3]

Pursuing one's ego ideal is the most powerful of all motivating human forces, and work is a primary method by which people do so. The process is facilitated when people integrate their own aspirations with those of the organization and their bosses, which occurs through processes of identification and acculturation. On the other hand, if one feels unsuccessful at work, the ego-ideal gap increases and self-esteem plummets. Typically, one then attacks the job and oneself harder to compensate for feeling inadequate. That further devalues one's sense of worth.

The heightened aggression that results may then be redirected toward the

self, giving rise to on-the-job accidents, errors, depression, as well as self-defeating behaviors such as alcohol, tobacco, and stimulant abuse. Aggression may be restrained and contained, thus giving rise to the psychophysiological reactions seen with simultaneous "stop-go" commands from the autonomic nervous system, or it may be displaced outward onto substitute tasks or inappropriate targets. Such compensatory behaviors often occur when an organization shifts its goals and modes of operating without sufficiently preparing its employees. The employees then feel increasingly inadequate, fervently persist in their old ways, and fall further and further behind.

Work is also a primary forum for meeting one's affiliative and social needs, which are important for strengthening self-image. If relationships at work fail to meet a person's needs for affection, respect, and being valued, the gap between that person's ego ideal and self-image widens further, yielding even lower self-esteem. Careful psychological studies[1] confirm the primary determinants of organization-based self-esteem to be managerial respect (affection), organizational structure (providing opportunities for mastery and relationships), and job complexity (allowing for ego-ideal aspirations to be met).

Interpersonal Model

As with purely social relationships, people are unconsciously attracted to work environments that reflect or complement their own coping styles, offer them opportunities to pursue their ego-ideal requirements, and enhance their self-image and self-esteem. The nature of the individual-organization bond is similar to dyadic or family ties in that each partner comes with many elaborate expectations of the other, both conscious and unconscious.[9]

The explicit expectations by the individual of his or her organization often concern concrete issues such as salary and fringe benefits. Conversely, the organization expects an honest day's work, commitment, loyalty, and conformity from the individual.

Less obvious are the implicit expectations individuals have that their organizations will agree to help them live up to their ego ideals. The individual expects the organization to offer personally meaningful goals for him or her, to be told clearly what is expected, to be assisted in acquiring skills and obtaining resources, and to be protected. The organization has parallel and reciprocal implicit expectations of its employees. When those expectations are not fulfilled, the individual experiences the stress or pain of a violated "psychological contract."

Psychological Contract

The psychological contract, a paradigm developed by Levinson[9], helps to clarify the different dimensions of this relationship in order to better understand what makes it work, and, conversely, what causes it to be destructive. The psychological contract asserts there should be a reasonable "fit" between the modes of coping for both the organization and the individual. The degree to which such a fit is lacking determines how much energy both must expend to compensate for the differences. Obviously, this energy is necessarily—yet unfortunately—diverted from the central work tasks of the organization and from meeting the individual's own ego-ideal needs. These expectations are implicit, are developed subtly, and are often made explicit only when violated. The three dimensions that best describe these expectations are dependence, distance, and change.

INTERPERSONAL DEPENDENCE:

Dependence refers to how much each "organism" envelops the other and supports the other's existence. The premise is that interdependence is necessary for mature functioning in groups in that it combats the guilt and mistrust experienced when depending on others and it builds toward a common purpose. Each wants the other to succeed, trusting that its own needs will be served as well. Therefore, each wants to create an atmosphere that fosters understanding of and meaningful responses to the legitimate needs of the other. When those conditions are met, both function optimally.

When the legitimate needs of one are denied by the other, feelings of hurt, anger, and abandonment result. Organizations do this when they fail to supervise their employees adequately, follow a "sink-or-swim" philosophy, or cut off opportunities for promotion or training. Similarly, individuals can deny the legitimate needs of their organizations by refusing to accept increased responsibilities.

When either entity exploits the other's dependency needs, stifled feelings of betrayal result, because it is often too dangerous to express anger toward a partner you rely on. Organizations can exploit an individual's dependency by acting paternalistically and preventing growth and emotional expression. An organization can over-supervise employees, for example, by just giving orders rather than providing the information and guidelines necessary for mastery and advancement. Alternatively, **individuals can exploit an organization by cornering the organization's resources, knowledge, and skills, thereby making themselves indispensable. Individuals may also seek to exploit their organization by consciously or unconsciously failing to develop their peers and subordinates.**

DISTANCE:

Given the interdependence between an individual and an organization, the optimal psychological distance between them is a negotiated product of competing forces of attraction and repulsion.

The forces of attraction between an individual and an organization are the pulls for affection and the needs to control and join their aggressive energies into shared tasks. Thus, an individual seeks to be liked and respected by his or her organization and to have that demonstrated by being given information and resources. The organization expects the individual to work hard toward the organization's goals, to be friendly to people at all levels, and to respect the organization's norms. **In order to meet their shared objectives, the individual expects to be given authority to make decisions and command organizational resources as well as to be rewarded for positive results. The organization expects its employees to accept its needs to retain sufficient control over their work activities to get the job done, to channel aggression into constructive tasks, to temper rivalry, and to play by the rules.**

Forces of repulsion are the needs of each for autonomy and universal, uncontrolled competitive instincts. **People expect the organization to respect their private life, to not look over their shoulder, and to represent them well to others. The organization expects individuals to respect trade and management secrets and to refrain from speaking negatively about the organization.**

CHANGE:

Because both the individual and the organization are constantly faced with change demands, the way in which the entire system views change and responds to it is critical

to understanding its functioning. **Change involves processes of detachment and reattachment, which require dual tasks: dealing with loss and coping with new demands. The efforts and effects of individuals adjusting to such change may interfere with their ability to support the organization's need to change, because individuals' attachments and investments (in roles, relationships, and methods of doing business) are often the basis of their identity and self-esteem.** Therefore, employees' self-esteem may be threatened when the organization demands changes in the usual behaviors. **If individuals and organizations become increasingly rigid, as can occur in the absence of training or preparation for change, their ability to respond successfully is diminished.**

Effective coping with change requires a mutual alliance. Individuals expect the organization not to change their positions without first explaining why it is necessary and by providing alternatives and choices. Furthermore, individuals expect to be helped to sustain position, role, and standard of living and to be supported by having their psychological "costs" of change acknowledged. The organization expects the individual to change (with restructuring) to meet the organization's needs, even if it is personally costly.

Adaptation Concepts

The third psychological concept with relevance to stress in the workplace is that of the adaptation response. Findings and hypotheses, from Cannon's[10] "fight-flight" physiologic response to Lindemann's[11] and Kubler-Ross's[12] research on the grief response and more-modern concepts like Flach's[13] resilience hypothesis, all identify **as normal the phases of disruption in human functioning that follow psychological trauma.** Just as the Chinese expression for crisis, ***wey chi,*** means both danger and

opportunity, the process of human adaptation to significant change begins with a critical deterioration of cognition, emotional stability, and behavioral effectiveness. If successfully endured and mastered, that will lead to spontaneous recovery, offering more mature, complex, and resilient functioning later. Successful and flexible adaptation to change requires a modulation of tension and restraint of the impulse to react prematurely in order to allow enough time to properly scan, analyze, and interpret the problem; to entertain fully any options before deciding on a course of action; to prepare the necessary supplies and support; and to adequately rehearse—all before acting.[14] Thus, the stress or arousal response, if appropriately attended, promotes survival and growth. When the change is positive, it is experienced as stimulating and pleasurable; when it is negative, it is experienced as painful and undesirable.

The sequence of disruption in functioning can be divided into four phases: (a) the initial impact, (b) disorganization (with a focus on loss), (c) recovery (after accepting the reality of loss), and (d) reorganization (when new learning skills are integrated with the old into a new identity). Support must be enlisted for the necessary tasks of grieving the loss and familiarizing oneself with the ensuing new demands and strategies.

Stress Overview

Building on those concepts, we can now view stress as a signal of disequilibrium: a disruption of the usual steady state of competing internal and external forces. The counselor needs to examine stress through several different lenses of human understanding, just as any medical practitioner compares symptoms against each organ system.[15]

When the fundamental imbalance is intrapsychic (i.e., conflicts between the mental structures of the mind: instinctual drives, dependency needs, ego ideal, conscience, and ego), we call the states anxiety, guilt, or fear. This stress is usually chronic and substantially self-inflicted. It derives less from the individual's current job, interpersonal relationships, or state of flux than from chronic feelings of inadequacy, unconsciously perceived danger, and an urgent need to compensate. Such chronic stress is trait dependent. It exists in many different settings for that person and is difficult to alter substantially. **The most crucial work variable affecting this type of internally driven stress is the individual's relationship with his or her superior. Projecting parental (ego-ideal) attributes onto one's boss and then striving for the superior's approval and respect is a powerful compensatory defense mechanism. Failure to gain that recognition may amplify one's self-reproach. Conversely, self-indictment may be projected onto one's boss, thereby perceiving disapproval in the absence of other feedback. Traditional psychodynamic therapeutic methods are applicable in treating such chronic stress, but significant relief of fear and helplessness often occurs simply by orienting the client to that frame of reference.** By clarifying his or her intrapsychic dilemma and proposing other behavioral options, the counselor can ally with the client's executive ego functions and soften the harshness of his or her ego-ideal indictments.

When the disruption is primarily interpersonal, the concept of a violated psychological contract is useful in diagnosing and treating work-related stress. By examining each dimension (dependence, distance, and change) of the client's relationship with his or her employer, one can often point out the failure to understand or to satisfy each other's expectations. By clarifying the ways in which a particular relationship deviates from the ideal, the appropriateness of the client's expectations—from both the client's and the organization's perspective—can be

reconsidered. At the very least, it often becomes clear that the pain has arisen from an unhealthy relationship with unfulfilled expectations, not from any incompetence on the part of the individual. **When the contractual violation is recent, and especially when it is precipitated by organizational change, strategies to assist the client in renegotiating his or her contract can be formulated. However, when the fit between underlying styles and drives has been consistently poor and strained, the stress is usually chronic and probably requires a job change.**[16,17]

Most acute or sub-acute work-related stress is a consequence of recent and significant changes on the job.[11] They may range from the obvious (being fired, demoted, or transferred) to the more subtle, such as alterations in reporting relationships or in methods of doing business. Various types of support are necessary at different times to help relieve the disruptions in emotions and functioning. The counselor must first rationally help the client to clarify what has happened and then assist the individual in figuring out why. Inevitable feelings of failure and guilt must be acknowledged and countered with appropriate explanations of the crisis process (i.e., that it is normal to feel this way).

During the first few months of critical organizational change, the client must be assisted in developing reduced and realistic personal expectations, because his or her energies and concentration often will be diverted and distracted from the primary tasks at hand. The individual should be encouraged to **clarify the personal and emotional meanings of the changes**, and at the same time begin to **prepare for new ways of functioning.** People also need to be encouraged to mobilize their natural support systems in order to counter their sense of despair and diminished self-esteem.

Even early manifestations of altered emotional functioning have strong implications for one's ability to work effectively. **The "busy-ness" that quickly sets in after significant change is usually unproductive activity geared towards discharging energy and clinging to the familiar.** During those early stages of change, **people must be protected from making poor, impulsive decisions and instead should be encouraged to take time to review what has happened.** The angry protest against reality (normally present for several weeks) needs to be acknowledged and absorbed and aggressive energy freed up to attack the new realities.

If that fails to occur, self-directed anger in the form of guilt and depression can further impair one's energies and divert attention from the tasks at hand. Conversely, **unacknowledged and unresolved anger can give rise to hostile, even paranoid ideation and behaviors that frequently result in attacking the organization rather than allying with it to meet its new demands.** After the sad realization of loss has been acknowledged and comforted, then the useful aspects of one's earlier coping mechanisms must be identified so that they may be retained and incorporated into new styles and skills necessary for successful adaptation.

Such requirements for support may be experienced by the individual as increased dependency needs, which in turn may amplify the individual's feelings of inadequacy, shame, and failure. It is essential to clarify the appropriateness of seeking support during crises and to provide authoritative permission, when necessary. **The client can mobilize many kinds of informal and professional support** in order to facilitate his or her innate resilience: personal expressions of comfort (which ease the sense of alarm); ego support (to facilitate gathering data, finding meaning, and generating options); support for one's identity and self-esteem (by clarifying purpose

and worth); faith (to counter feelings of hopelessness); and, occasionally, a selective "taking over" (by giving directions in the face of dangerously immobilization).

When the trauma far exceeds the individual's existing coping mechanisms, a predictable decline beyond simple distress can occur. Feelings of entrapment, with associated loss of confidence about recovery, generate only feeble efforts at facing and mastering the tasks at hand. Recovery is still possible with sufficient encouragement and problem-solving support, but it requires a more active intervention by a counselor. Less reversible are the graver, progressive feelings of despair (feeling no control over one's destiny), apathy, and defeat. **With those forms of "battle fatigue" and "burnout," the counselor's energies must be directed toward rekindling hope, effort, and feeling. Otherwise, the chances of recovering former states of resilience, mastery, and flexibility once in those deeper stages are negligible.**

Diagnostic Process

Accurately locating the sources and meaning of "pain" requires **gathering data and making inferences.** The information needed when clients demonstrate work-related stress is similar to that required for most clinical investigations: **Who is involved? What are the manifest problems, attempted solutions, and current dilemmas? What is the desired outcome?**

The inferences involve locating the pain—that is, who experiences it and/or is the system itself in pain—and then determining its onset (acute or chronic). Those inferences are aided by developing "psychological profiles" of the individuals and the organization (how they handle affection, aggression, and dependency needs, and the nature of their ego ideals), and by evaluating the psychological contract between the

individual and the job (how good is the fit; are legitimate dependency needs denied or exploited; does the psychological distance allow for mutual respect, reasonable control and privacy; is systemic change handled fairly and reciprocally). Finally, during significant organizational change, several factors must be assessed: the degree of perceived control by the individual over the changes; the inherent resilience and flexibility of both the individual and organization; whether the expectations of the process and its outcomes are realistic; and the availability of energy, support, and resources in the system and for the individual.

Treatment Process

The old adage that accurate diagnosis is 90% of effective treatment holds true in dealing with stress in the workplace. By employing the diagnostic processes described above, the counselor can reliably pinpoint the areas of greatest distress for the individual. The modes of intervention depend largely on the type of problem and on the style, skills, and orientation of the counselor.[15] However, they begin with a common denominator, namely, the better one understands what he or she actually faces, the greater the sense of personal control and, subsequently the greater the ability to focus energies on influencing reality and improving the behavioral effectiveness.

Thus, explicit and simple explanations by the counselor of his or her formulation for the client should be the starting point for all interventions that follow.

Examples

Two case studies illustrate typical situations involving work-related stress.

CHRONIC STRESS: INTRAPSYCHIC PROBLEMS ADDRESSED BY CHANGING ONE'S PSYCHOLOGICAL CONTRACT:

M.P., a 52-year-old male married high school principal, was referred by his superior because of increasing depression and migraine symptoms. Once the client's endogenous components were treated pharmacologically, his life-long patterns of perfectionistic strivings, need for approval, and aversion to conflict re-emerged and he then resumed his powerful self-imposed pressures. He felt he had to simultaneously resolve all conflicts and satisfy all needs of students, faculty, administration, and community. Although he was extremely intelligent, effective, and widely admired, he soon felt helplessly entrapped and his migraines again worsened.

Once the psychodynamics were understood (i.e., harshly demanding ego ideal, powerful reaction formation, etc.) and the rigidity of his defenses was clarified, the vicious cycle was explained to the client and (with his permission) to his boss. They were encouraged to develop very clear guidelines to limit M.P.'s responsibilities and efforts to only those necessary for his executive role; the remaining duties were explicitly delegated. M.P. and his boss contracted to meet regularly to review his work style and reinforce his value as a resource and friend. Psychotherapy (limited by the client's alexithymia) focused on grieving the loss of freedom to tackle all of the problems and establish a competing ego ideal, valuing a more balanced lifestyle.

VIOLATED PSYCHOLOGICAL CONTRACT SECONDARY TO SIGNIFICANT ORGANIZATIONAL CHANGE:

R.D., a married 42-year-old male administrator of a community hospital's clinical service, was referred by his family doctor with panic attacks of recent onset

and mixed anxiety/depressive symptoms. He was a bright, confident, and conscientious manager—strongly analytical and also proud of his ability to treat his staff fairly and respectfully. During the previous year, the hospital in which he worked changed administrators—in part because of the increasingly competitive health-care environment. That was part of a deliberate shift in philosophy from being committed primarily to quality and serving people (which was my client's shared value system with the hospital) to becoming far more aggressive, cost-cutting, and market-oriented. His ability to sustain his department's technical quality and his staff's morale diminished quickly. He felt himself becoming a failure and was unable to argue persuasively with senior management for his department's needs. His frustration and anger were amplified by thinking he was now "losing it."

Once the anxiety/depressive symptoms were contained with medications, the client was helped to see how his psychological contract was unilaterally changed by the hospital and that their respective value systems were now frequently in conflict. He was then guided in a decision-making process through which he realized he was not prepared to change jobs and move in the near future. That freed him to shift from a caretaking/protective managerial posture toward one of helping to prepare his staff to understand and deal with the new realities and to help them find new ways to support themselves within the organization. He was then able to reduce his emotional investment in his hospital identity and shift his creative energies toward coaching and sports activities outside of work. Finally, he was helped to grieve the loss of "the good old days" and to view the work changes as more sad than evil.

Prevention

Preventing mental or behavioral problems from arising in any organization requires an understanding of the intrinsic strengths and vulnerabilities of that ecosystem and the forces that threaten its equilibrium. **Primary prevention involves reducing, eliminating, or preventing such noxious destabilizing forces and enhancing the adaptive capabilities of the entire system.**[18]

Organizational consulting firms, such as the Levinson Institute, translate clinical principles into useful paradigms and seminars for executives who must lead and engineer changes in their organizations. These industry leaders recognize that it is simply "good business" to create atmospheres that encourage their employees to be successful and productive. They may also proactively employ clinically-based consultation when their companies anticipate making significant changes in order to best prepare for the types of support their employees will need and to facilitate the subsequent renegotiation of psychological contracts. For any plan to be successfully implemented, it must not only be technically sound, but it must also be accepted and "owned" by the very employees who must implement it.

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QUESTIONS BASED ON THIS LESSON:

5. Which of the following models is not presented by the author as a framework for understanding the relationship between work environments and human health and behavior?

   A. Psychodynamic

   B. Biopsychosocial

   C. Interpersonal

   D. Adaptive

6. Which of the following statements is correct?

   A. People with a need to give affection are mostly likely to seek careers in electrical engineering

   B. Individuals with strong aggressive drives commonly choose careers in teaching and health care

   C. Transference of parental attitudes onto superiors at work rarely, if ever, occurs

   D. When organizations shift goals without sufficiently preparing employees, employees often feel inadequate and persist in outmoded ways of behavior

7. Which of the following statements is correct?

   A. Interdependence and trust are unnecessary for mature functioning in groups when power is concentrated in a few hands

   B. The individual who fails to develop peers and subordinates is behaving exploitively, violating the psychological contract between the individual and the organization

   C. The "distance" dimension of the employer-employee psychological contract simply provides for adequate vacation time

   D. Organizational changes rarely induce stress among employees and little preparation for change is required

8. In the management of work-related emotional distress, clinicians can best:

   A. Help the individual regain self-control by identifying the real issues and events involved

   B. Always direct the individual to seek a job elsewhere

   C. Reveal the individual's private feelings to his or her employer without permission

   D. Presume the problems are entirely intrapsychic and that if the individual undergoes psychotherapy he or she will be able to remain healthy in any working environment

Directions in Rehabilitation Counseling

VOLUME 3 • LESSON 3

Women and Alcoholism

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EDITOR'S NOTE

Although alcoholism is still much more common among men, its incidence seems to be increasing among women. There appear to be special characteristics in alcoholic women, who are estimated to total between one and two million. Women generally consume less alcohol than men; however, perhaps because of lower weight and lower body water content, their intoxication threshold and metabolism of alcohol differ significantly.

Women from lower socioeconomic backgrounds tend to be heavier drinkers, drink more often in bars, experience delirium tremens and liver damage, manifest suicidal behavior, and have encounters with the law. Those from higher socioeconomic groups tend to conceal their drinking, have a later onset of their problem, manifest a course of illness that progresses rapidly, and reveal serious interpersonal and family difficulties.

Women alcoholics often have a childhood history of abuse, including sexual abuse. Often their husbands have drinking problems. The evidence for a genetic/familial factor in female alcoholism is not as strong as among male alcoholics.

Alcoholic women seem to use alcohol to reduce anxiety; they experience the effects of alcohol as beneficial (in contrast to males), and turn to it to cope with life's difficulties. Sexual conflicts, conflicts over sex roles, and struggles over dependency are all common psychodynamic themes.

Treatment plans should pay due attention to both diagnostic and psychodynamic considerations. One must keep in mind the strong stigma that blocks the female alcoholic from reaching out for help. Practical measures, such as occupational rehabilitation to help patients secure marketable skills and thus build self-esteem or family counseling to remedy the damage done to interpersonal relationships by drinking, are vital. The gender of the psychotherapist does not seem to be as critical a factor in treatment as is the attitude of the therapist toward women patients, since self-esteem is such a central theme.

Introduction

A strong tendency to see alcoholism as a unitary phenomenon and as homogeneous persists. Specific characteristics of population subgroups—such as alcoholics with psychiatric problems, women alcoholics, elderly alcoholics, and adolescent alcoholics—have recently been accorded more attention in research literature and in treatment programs. **Research in the past two decades has established differential features of male and female alcoholics in reference to drinking patterns, biomedical and social consequences, and psychiatric features.**

Clinical investigators as well as the popular press have promoted the belief that alcoholism in women is on the rise. Reviews of national surveys and treatment populations continue to demonstrate that **men of all ages and socioeconomic levels consume more alcohol, drink more frequently, and, in many cases, demonstrate more marked sequelae from their drinking problems than women.** However, **women appear to suffer more adverse consequences of heavy drinking in the area of interpersonal relationships.** Also, it is notable that **female adolescents have significantly increased their drinking,** which may be indicative of a shift in social attitudes, with less severe social stigma attached to alcohol use and abuse in women.[1]

Epidemiological studies of the past 20 years have ascertained varying ratios of male-female alcoholics as they relate to treatment setting. Some studies have determined that the ratio of male to female alcoholics in different population subgroups, such as state psychiatric hospital inpatients, varies from 5:1 to as low as 3:1; **in outpatient clinics the ratios may be 4:1 to 5:1, whereas in private hospitals, the male to female ratio could reach 1:1, a finding also seen in private office practices.**[2] Although gender prevalence figures continue to be debated, **all available information indicates a progressive trend**

toward a lower ratio of male to female problem drinkers, both in the general population and treatment systems. Women alcoholics have been estimated to number about one to two million.[3] The additional evidence that increasing proportions of women are using alcohol and that more are developing a pattern of heavy drinking warrants concern from a public health perspective as well as from a clinical viewpoint.

Drinking Practices, Symptomatology, and the Course of Illness

The prevailing understanding of alcoholism is based on male samples. The diagnostic criteria, as promulgated in DSM-III, do not specifically consider whether patterns of pathological drinking, the social or interpersonal distress, the biomedical sequelae, or the course of the disorder development over time can be differentiated qualitatively or quantitatively with regard to possible gender differences.

In 1980, Polich and colleagues identified "6 core symptoms of alcohol dependency." These were identified as "tremors (shakes), morning drinking, blackout, loss of control, missing meals because of drinking, and continuous drinking bouts of 12 hours or more." Although the study was performed on a male sample, other comparable studies indicate that once the alcoholism syndrome has developed fully, women show only insignificant differences in degrees of symptomatic dependency.

Some dispute continues regarding the use of definitions and diagnostic standards relating to levels of alcohol intake in reaching a diagnosis of alcoholism in male versus female drinkers. It has been established that women who drink socially as well as

female alcoholics who present for treatment do drink considerably less than men. One large-scale study reported that women accepted for treatment averaged only 4.5 ounces of absolute alcohol a day as compared with their male counterparts, who averaged 8.2 ounces per day. This observation appears to relate to differences in body weight and body water in women; it may also relate to metabolism and hormonal factors that are in the process of being studied.[4] Recent work strongly suggests an operative physiological factor; women reach higher peak blood alcohol concentrations (BACs) than men when taking in the same dose, with body weight being taken into consideration, since women have a lower body water content than men.[5] One should note that commonly used screening tests have primarily been developed with male population groups in mind.[4] In 1976, Jones and Jones reported significant differences in "blood alcohol levels, variability of peak levels, and metabolic rates of alcohol in women" when compared with men given the same dose.[6]

Many women who develop alcoholism tend to have the onset of problem drinking at an older age than men; studies indicate a difference of approximately 4–8 years. However, what further distinguishes women is that the history of the problem drinking is shorter. Another issue relating to the question of intake quantity and frequency in establishing an alcoholic diagnosis is the realization that male alcoholics, who drink nearly twice as much and weigh much more, may have different cut off points for defining hazardous drinking. Failure to consider this fact can lead to underestimation of the diagnosis in women at the time of intake. One of the most popular screening tests, the Michigan Alcoholism Screening Tests (MAST), was initially tested on an all-male group; the questions appear to be written more for men.[6] Another caveat unknown to many is that the initial studies on the nature and causes of the disease of alcoholism by Jellineck, which included a review of the progressive development of symptoms in approximately

1000 members of Alcoholics Anonymous, contained only men in the series and thus contributed to a long-standing view of the typical alcoholic as male.[4] One should also be aware that the long-standing social disapproval of drunkenness in women can lead to underreporting of drinking problems in them.

Male and female alcoholics appear to differ significantly with regard to socioeconomic status. Women of lower socioeconomic status are heavier drinkers; drink more frequently in bars; go on binges; experience D.T.'s, liver damage, suicidal behavior, more alcohol-related arrests, and more loss of friends and jobs. On the other hand, higher-status women approximate the stereotyped model of the woman alcoholic. They conceal their drinking, have a later onset of problems, and are older; their drinking pattern is telescoped, they lose control more quickly, they drink more at home, they have more family problems, and they report fewer prior hospitalizations. The lower-status women more closely resemble male alcoholics, who, incidentally, were frequently studied in lower- or middle-class treatment settings.[2]

Sensitivity is required to assess areas about which women ordinarily feel protective, such as their image as a parent, coping pressures attendant with developing dual careers (homemaker and professional), and the often noted propensity of physicians to diagnose and treat with psychotropic anxiolytic agents women who present with stress-related symptoms of anxiety, depression, and fear. Unfortunately, many physicians tend to overlook alcohol-related sexual difficulties, alcohol/drug interactions, and clinically important parenting responsibilities. A most sensitive problem, now becoming more apparent in the alcoholism literature, is the issue of sexual abuse in the forms of incest, child molestation, and rape frequently found in the histories of women alcoholics.[5]

Reviews of men and women alcoholics in clinic populations have demonstrated that **women do not commonly engage in binge drinking.** Amounts of alcohol consumed are lower, as is frequency. **There is also a shorter period of time elapsing between the onset of the drinking problem and their coming to the treatment facility.** Another frequently debated issue is whether **women are admitted to treatment with less severe problems, but suffering from the impact of specific stressful events,** such as domestic crises, **contributes to their seeking and accepting treatment at an earlier stage of the illness.**[9]

Numerous studies suggest more-adverse consequences of alcohol abuse among **men; more jobs are lost because of drinking, more hospitalizations and arrests occur, more sociopathic behavior is seen.** Women, on the other hand, demonstrate more drinking-related problems in the context of family or marital disruption.[7]

Early Life Stresses versus Genetic Influences

In the 1970s, Goodwin's Danish adoption studies provided great impetus for the clarification of genetic factors in alcoholism. This study of children of alcoholics established that **adopted-out sons of alcoholics were about four times more likely to be alcoholic than were adopted-out sons of nonalcoholics, regardless of who raised them. A concurrent study on adopted daughters of alcoholics did not establish conclusively that vulnerability for alcoholism was genetically related in women.**[10] This landmark study provided strong evidence for a genetic factor in the causation of more severe forms of alcoholism in males. Although this study did not show a difference in the incidence of alcoholism between adopted-out daughters with biological parents who had a history of hospitalization for alcoholism, Goodwin did not rule out such a

factor, and suggested the possibility of a greater environmental influence in female alcoholism than that found in male alcoholism. Although he found a rate of alcoholism of 18% among sons of alcoholic parents (four times that of sons of nonalcoholics), the incidence in daughters was much lower, about 3%–4%. However, this is still higher than the expected rate of alcoholism for Danish women, which is less than 1%. Although he speculated that the daughters might be genetically susceptible, he considered that female daughters might be culturally protected from becoming alcoholic. However, Winokur's studies indicated an overlap of alcoholism and depression, with the disorder being familial.[11] A more-recent contribution of female adoption studies (1982) involved the genetic perspective study of 913 Swedish women adoptees, of whom 51 had alcoholic biological mothers and 307 alcoholic biological fathers. Results indicated an incidence of alcoholism three times greater in the adopted daughters of alcoholic biological mothers than in the adoptees of nonalcoholic mothers. Although there was a trend towards alcoholism in the female adoptees from alcoholic biological fathers, with or without a history of criminality, there was no significant increase of alcoholism in this group. The comparable incidence of alcoholism in what he calls the highly hereditable "father to son inheritance" indicated the male adoptees to be characterized by the adolescent onset of alcoholism, a history of serious criminality, and an incidence of alcoholism nine times that of male adoptees from nonalcoholic biological parents.[12]

The high incidence of alcoholism among the first degree relatives of female alcoholics strongly supports a genetic predisposition. Family history studies provide evidence that familial transmission does occur in alcoholism. Holinger's study on relatives of male and female alcoholics determined that the mode of familial transmission did not differ between female and male alcoholics.[13] Such familial contributants emphasize the need to

give serious thought to strategies of intervention and prevention on behalf of the children of alcoholic parents.

Contemporary Stress as a Trigger

Numerous studies maintain that precipitating stressful events—such as marital problems, divorce or separation, death of a loved one, obstetric or gynecologic problems—contribute to the development of alcoholism in women.[1] The impact of adult stresses is compounded by **the high rates of early-life disruption found in the histories of female alcoholics,** such as death of a significant family member, parental separation or divorce, and psychiatric problems including psychosis or alcoholism in parents or other close relatives. Male alcoholics and women with other psychiatric disorders report similar experiences, but alcoholic women seem to report more experiences of this nature.

Pre-alcoholic women may well be more sensitive to interpersonal loss and vulnerable or predisposed to the development of depressive symptomatology, lower self-esteem, and long-standing feelings of loss, sadness, or anger, all of which become prominent issues in their maladaptive use of alcohol to cope with current stress and modulate affect states.[1]

A number of alcoholic women are children of alcoholic fathers, raising the questions of an etiological contribution via cross-sex modeling. **Mothers of alcoholic women have been characterized as being cold, severe, and domineering, whereas fathers have been characterized as warm, gentle, but often alcoholic.[7] The existence of very low self-esteem may be a central feature in women alcoholics, contributing to their poor self-concept.** The assessment of these factors is critical in determining to what degree the excessive use of alcohol plays a role as a maladaptive coping mechanism for women patients. **Beckman emphasized the need for treatment programs to increase**

the level of self-esteem in female alcoholics and promote adequate recovery. In psychotherapy, clinicians should address the effects of early life experiences of alcoholic parenting as they affect identification and self-concept.[7]

A recent upsurge in the reporting of sexual abuse among women clients in alcoholism programs had previously received minimal research attention. Recent reports indicate that as many as 45%–70% of clients in surveyed programs had been victimized. There does appear to be a relationship between the presence of alcohol abuse in families where incest occurs; the children of such families continue to experience alcohol-related problems themselves as adults or in their marital partners. A survey by Black found that of 200 adult children of alcoholics, 30% of the women reported incestuous relationships, 33% were alcoholics themselves, and 35% married alcoholics.[14] Another study, completed over a three-year period on women alcoholics, revealed that 63% of the patients reported they had been victims of rape or incest before the age of 14.[15] The severe impact on the developing child and adolescent of this form of physical and psychological abuse may be a stronger contributing risk factor than previously determined.

One must also note a very high prevalence of alcoholism or problem drinking among husbands of alcoholic women, with rates in samples varying between 20% and 74% of active alcoholism or problem drinking in husbands, and rates of 24%–38% of broken marriages in alcoholic women.[9]

Biomedical Aspects

Biomedical aspects of alcohol related disorders have received greater emphasis in the effort to determine sex-related differences that could contribute to a broader understanding of the development of alcoholism in men and women. A number of areas are now considered meaningful in differentiating male versus female alcoholism. The accepted

high morbidity rates include detrimental effects from alcohol's point of entry though many of the organ systems of the gastrointestinal tract. Commonly seen alcohol-related nutrient deficiency (vitamins and trace elements) contribute to illnesses such as anemia, small-bowel dysfunction, and more severe disorders such as Wernicke's encephalopathy. The organ most often affected appears to be the liver, with hepatitis and cirrhosis being frequent hospital-diagnosed medical concomitants of alcohol abuse.

Alcohol consumption has also been determined to interfere with the endocrine system, as seen in male impotency and the onset of postmenopausal amenorrhea in women alcoholics. Neuroendocrine effects are suggested by the findings of frequent gynecologic disorders, including miscarriage, greater than expected rates of infertility, hysterectomies, sexual dysfunction, and the risk factor in determining the outcome of pregnancy (fetal alcohol syndrome).[16]

The other area most commonly studied involves cognitive functioning and neuropsychological deficits. Deficits in cognitive impairment are more evident in older alcoholics, but studies are now beginning to differentiate age of onset of drinking, sex differences, and the degree of recovery of cognitive function after cessation of drinking. The areas of deficit involve learning, memory, abstract reasoning, and perceptual organization.[17]

Alcohol Use and Female Sex Hormones

Numerous gynecological problems occur among female alcoholics. Moreover, alcohol probably affects the secretion and metabolism of sex hormones in both sexes, such as estrogen, progesterone, and testosterone. Alcohol consumption impairs the production of sex steroids in healthy men as well as in those who are

chronic alcoholics. Alcohol is apparently a testicular toxin. It also interferes with the function of the hypothalamic-pituitary-gonadal axis, an observation that has more recently stirred interest.[18]

In spite of the frequent associated findings of gonadal dysfunction as indicated by menstrual abnormalities, changes in sexual characteristics, infertility, and ovarian atrophy, **the literature remains deficient in providing any clearcut data about the effect of alcohol on plasma concentration of sex hormones.** One study of healthy women reported that administered alcohol had relatively little effect on such plasma concentrations.[18]

The male clinical syndrome related to hypothalamic-pituitary-gonadal axis impairment is demonstrated by impotence, testicular atrophy, sterility, feminization (loss of male secondary sex characteristics), **and gynecomastia. In women there is preliminary documentation of a female syndrome of menstrual abnormalities, anovulation, signs of estrogen deprivation in the uterus and fallopian tubes, and placental malformation.**[19] A few studies report that chronic excessive alcohol consumption may induce early post menopausal amenorrhea or even ovarian failure.[16]

To date, few empirical studies have measured plasma hormone levels at different phases of the menstrual cycle in women using or abusing alcohol, particularly those with long-standing alcohol dependence. Studies have demonstrated some differences between the effects of single doses of alcohol in normal men and women. Based on body weight, **women appear to have higher and more variable peak blood alcohol levels, particularly during the premenstrual phase.** Some women report the onset of excessive drinking in the premenstrual period in order to cope with higher levels of tension and depressed feelings.[18] **Women taking hormones—birth control pills or**

estrogen replacement—have been found to metabolize alcohol more slowly. There is also some evidence that women spontaneously will lower their drinking consumption during pregnancy.[4] Jones and Jones published a study investigating alcohol metabolism in women with or without oral contraceptives at all three phases of the menstrual cycle. Results supported their previous impressions of a decreased rate of alcohol metabolism and a lower peak BAC in women using oral contraceptives. Significantly, they would also have alcohol in their system for a longer period of time, although the psychological effects of alcohol might be lessened by their not achieving as high a peak BAC. Thus, women on the pill may tend to drink less alcohol.[5,6]

Fetal Alcohol Syndrome

The recognition of alcohol-related birth defects has led to the investigation of the frequency and significance of what is commonly known as the fetal alcohol syndrome (FAS). A number of clinical investigators have established that FAS consists of a characteristic cluster of features: (1) Pre- and post-natal growth deficiency; (2) facial dysmorphic features; and (3) central nervous system dysfunction presenting as mental deficiency of varying degrees of severity.

Alcohol's teratogenic role has been demonstrated through its adverse biological consequences on the human fetus when exposed in utero. These include organ system malformations, intrauterine death, and pregnancy wastage, along with abnormalities of the central nervous system manifested indirectly as behavioral deficits or learning disabilities. Studies have revealed central nervous system complications, including psychomotor retardation during development, tremulousness, hyperactivity, and short attention span. Abnormal electroencephalogram patterns have been seen in

newborns and children with FAS. Also noted are cognitive and intellectual deficits in children born to alcoholic mothers, even when they did not demonstrate the full characteristic features of FAS. Although the prevalence of FAS and alcohol-related birth defects has not yet been accurately determined, studies from other countries such as Sweden indicate a 33% prevalence rate for the full syndrome and a 76% rate for partial effects among the progeny of alcoholic women. Chronic maternal alcoholism is also associated in these studies with lower socioeconomic class and other risk factors such as additional drug use, smoking, and poor nutrition. As there appears to be a dose-response relationship between intrauterine alcohol exposure and adverse pregnancy outcome, it will be important to establish safe levels of alcohol use during pregnancy. It is obvious from what we know to date that it is extremely important to evaluate all pregnant women for excessive drinking to determine the risk factor and to develop more effective intervention strategies for these women with high-risk pregnancies.[20]

Studies investigating alcohol consumption during pregnancy have usually depended upon self-reporting of drinking patterns; they have also used lower amounts of alcohol intake (e.g. two drinks per day, 1 oz. absolute alcohol) as measures of heavy drinking. Many effects on the fetus have been associated with alcohol, such as premature birth, spontaneous abortion, stillbirth, postpartum hyperactivity, feeding and sleeping abnormalities, and later learning disabilities.[21] Considering the potential dangers, a precise, careful assessment of drinking pattern is an opportune method of prevention and intervention. As we become more aware that adverse effects of alcohol on the fetus or the full FAS are a composite of effects of dose-related exposure to alcohol at different developmental stages, it is of major importance to intervene and insure a healthier course for fetal development. The serious sequelae—brain microcephaly, growth defects, mental retardation, and more subtle defects—demand that this problem be given serious attention.

Liver Disease

Morbidity from all causes appears to be as prevalent among women with alcohol- related disorders as among men. But there are some indications of an acceleration of morbidity in women, as women present with an "equal risk of illness following a shorter duration of heavy drinking." Studies as far back as 1945 indicated that women developed portal cirrhosis more often than men and died at an earlier age. Other studies have substantively demonstrated sex differences in the incidence of hepatitis and cirrhosis of the liver. Although samples of cirrhotic alcoholic patients tend to indicate that men are more often affected with liver sequelae than women (approximately 1.6-2.7:1), the relative risk of liver disorder in women is actually higher when comparing the fewer women alcoholics to the greater number of male alcoholics. Women also demonstrate a shorter history of excessive drinking (13 years vs. 20 years) and a higher risk of hepatitis.[13]

Cardiovascular Effects

The connection between cardiovascular disease and heavy drinking is reflected in hypertension, cardiomyopathy, and arrhythmias. The cardiovascular effects are complex, and other risk factors such as smoking, nutrition, and lifestyle must be considered in any evaluation. Alcoholic cardiomyopathy may be greatly underdiagnosed, even though there is an established association of this disorder with excessive drinking over a 10-year period. The relationship between hypertension and moderate alcohol consumption is dose related and appears to affect both males and females of all races, with white males being most vulnerable.[22]

The Cancer Risk

In the area of cancer studies, of which there are many, it is known that **heavy drinking increases the risk of cancer of the tongue, mouth, oropharynx, hypopharynx, esophagus, larynx, and liver. The women studied appear to have greater risk for cancer of the lip, tongue, pharynx, and esophagus. Alcohol is also considered to promote tobacco carcinogenesis.** It is noteworthy that Williams and Horn observed a **decreasing risk of cancer along the digestive track paralleling the progressive dilution of alcohol as it passes through the intestinal system—with the risk highest in the oral cavity. In both males and females, cancer of the mouth and the esophagus was related more to drinking than to smoking, with the opposite being true for cancer of the larynx.**[13]

Central Nervous System Effects

Psychological and neurological studies have established structural brain damage in alcoholics. Although studies of neuropsychological function in alcoholic women are still rare, in one well-designed study, Hatcher and co-workers found that **"alcoholic women when compared to non-alcoholic women showed both spatial and verbal abstracting deficits."** Earlier reports had demonstrated only spatial abstracting difficulties in male alcoholics.[13]

Numerous studies that employed psychological testing have disclosed many deficits in sensorimotor performance, perceptual capacities, conceptual shifting, visual-spatial abstracting abilities, and memory function.[16] Alcohol—a potent neurotoxin—may produce diffusely distributed brain damage with accompanying neuropsychological deficits. Various hypotheses have been tested recently to establish whether or not chronic

excessive consumption of alcohol may induce premature aging or may affect biological mechanisms that normally regulate the process of aging and, as a consequence, deteriorate alcoholics' brains at a faster rate. This is called the "accelerated aging hypothesis."[23] The development of a distinct pattern of cognitive deficits, particularly in the areas of visual, spatial, and visual-conceptual tasks, have led researchers to suggest that alcohol selectively disrupts functioning of the right cerebral hemisphere. Other researchers have postulated that alcohol impairs the integrity of the frontal system, due to the patient's inability to formulate problem-solving strategies or test hypotheses in a systematic fashion. The performances of women social drinkers on verbal memory tasks vary during the menstrual cycle, and that alcohol may more seriously impair performance at times of low sex hormone levels.[24] Of considerable clinical significance is that cognition often improves with prolonged abstinence.[23]

Psychodynamic and Psychopathologic Considerations

A common clinical impression proposed in the alcoholism literature was that women alcoholics demonstrated more psychopathology than their male counterparts. This was based on clinical reports of more psychiatric treatment, more hospitalizations, more treatment for depression, and more reported anxiety and low self-esteem. Also noted were high suicide rates. A greater likelihood of psychiatric illness among relatives of female alcoholics has also been observed. These correlations have been debated more recently, as a greater effort to treat women with alcoholism has been made and the question of the degree to which social stigma may have been influencing psychiatrists in their evaluation and treatment approaches to women has been raised.

Currently, there seems to be agreement that one major clinical feature of women alcoholics is low self-esteem and poor self-concept; pathological dependency is thought to be a more common feature among male alcoholics.[25] Another frequent theme in women is sex-role conflict and its association with inadequate feminine identification. The extent to which self-esteem issues and sex-role conflict set the stage for alcoholism or result from alcohol abuse remains unclear.[25]

Concomitant Depressive Disorders

Studies that have focused on affective disorder in association with alcoholism in women have established an expectation that 25% of women diagnosed as alcoholic will also fulfill DSM-III criteria for a depressive episode during periods of abstinence or prior to the onset of pathological drinking patterns. One study involving upper socio-economic women reported a rate as high as 60%. In addition, psychological tests have reported higher rates of depression, anxiety, and guilt when compared with male alcoholics. Of serious clinical importance are the reported increased rates of suicide attempts for this group of women, although general population studies reveal higher rates for women in general.

This depressed subgroup of women alcoholics appears to present for treatment with a later age of onset of alcoholism, fewer prior years of alcoholism, more previous hospitalizations, more suicide attempts, and less evidence of medical consequences. They have a better prognosis than other female alcoholics, according to three-year follow-up studies.[2]

What is the treatment priority for this group of impaired women who may present with two concurrent, serious, potentially life-threatening conditions? There is still much

controversy within the alcoholism treatment field, particularly regarding philosophy of treatment as it relates to use of such psychotropic agents as antidepressant medication. Treatment should probably include close monitoring and the initiation of antidepressant medication in conjunction with alcoholism counseling, therapy, and Alcoholics Anonymous. Validation of the history of depressive episodes is critically important. Observations of the patient in a drug-free state over a period of time (preferably 30 days) is needed to establish the presence or absence of an associated depressive disorder. Most alcoholic patients demonstrate many depressive symptoms, particularly immediately after detoxification. Those with basic affective disorders are probably overrepresented in inpatient psychiatric units and often require readmission due to suicide attempts by overdose.

Antisocial or Sociopathic Behavior

Another subtype, particularly found in clinical samples of male alcoholics, involves antisocial or sociopathic personality disorder. Rates of 25% have been determined in male, but only 8% in female, alcoholics. This group generally has a poorer prognosis. It is distinguished clinically by an earlier onset of drinking, serious antisocial behavior, serious behavior and academic problems in school, troubled family structures, and even police confrontations. Such patients are younger at the time of hospitalization and reveal greater marital disruption in their history.[2]

A few rigorously designed studies have assessed personality or character subtypes, particularly affective disorder and antisocial personality in hospitalized women alcoholics. The associated features of a greater incidence of illicit drug use and abuse by antisocial alcoholics may be compounded by unexpected findings of their experi-

encing serious psychiatric symptoms consistent with diagnostic criteria for depression and phobic disorder, as well as short-lived but highly troublesome manic symptoms. When taking all the above into consideration, and understanding that antisocial alcoholics are known to present with alcoholism at an earlier age, undergo treatment for alcoholism at an earlier age, have more encounters with legal authorities, and report more treatment episodes (including hospitalizations), the initial diagnosis can be hard to make, and certainly the prognosis for this group may be unclear.[36]

Alcohol and Minor Tranquillizers

A number of women alcoholics have abused or misused prescription drugs in conjunction with alcohol. Increasing numbers of women presenting to Alcoholics Anonymous and to clinics are revealing concurrent drug abuse, particularly of anxiolytic agents (benzodiazepine-type). This group, often in the middle and upper socio-economic classes, can present with complicated withdrawal symptoms. A 1972 survey by Jones and Howard found that internists and family physicians could frequently establish the diagnosis of alcoholism, but they often provided anxiolytic agents as the treatment of choice for alcohol dependence. Significant inroads have occurred through NIAAA- and NIDA-sponsored Career Teacher Programs in medical schools where curricula were developed to educate and influence attitudes of medical students in all areas of substance abuse. A survey of female members of Alcoholics Anonymous by James found that 35% of women had abused drugs in the past and that these were mainly prescribed by their physicians. Schuckit and Morrissey reviewed the records of 293 women in alcoholism treatment centers and found 80% had obtained prescriptions for drugs with the potential for abuse. The current impression is that women alcoholics—particularly those under 40 years of age—may abuse other drugs more often than men and appear to present more frequently to emergency

rooms with overdoses, tend to involve two drugs, with alcohol and a psychotropic agent being the most frequent combination.

At present, there is general agreement that as many as one third of alcoholic women meet criteria for clinical drug abuse, a majority of them misusing a prescription psychotropic drug usually given them by a physician.[13]

The Antianxiety Role of Alcohol

A long-standing clinical theory has been the "tension-reduction hypothesis" of alcohol use and abuse. Although there is a dearth of controlled studies that explore this assumption, two studies do support the hypothesis that alcoholic women experience more anxiety-reducing effects from alcohol and describe a more positive emotional or mood state as a consequence of prolonged drinking (men reportedly experience more negative affects); these women may also present with higher levels of psychosocial and physical problems, using alcohol to cope with stressful life events. The recognition that alcohol may have been used to reduce anxiety—or, at least, to expect such an effect—helps explain the tendency to abuse psychotropic anxiety reducing medications as well.[27]

Borderline Personality Disorder

Another psychiatric diagnostic subtype that has not been studied in a systematic way but that has received attention is that of the alcoholic with a borderline personality disorder. In one study, using conservative criteria and structured diagnostic interviews, 12.8% of hospitalized alcoholics in a psychiatric inpatient unit were found to be borderline. In another study, 39% of alcoholics were estimated to be borderline, and another nonrigorous study of addicted physicians reported a 28% incidence of this

diagnosis. The populations studied include women, although the actual breakdown was not given. Alcoholic-borderline patients appeared to be younger, have a high rate of other drug abuse, reveal a greater degree of generalized dysphoria and a greater frequency of acting out behavior, particularly suicide attempts and other self-destructive experiences. There was no discernible difference in their pattern of alcoholic drinking, except that craving was induced by positive experiences rather than by negative or stressful situations.[28]

Phobic Anxiety States and Panic Disorder

Quitkin and Rabkin reported on four studies in which high rates of alcoholism were found in patients diagnosed as having panic disorder.[29] Another report, by Mullaney and Trippett, indicated "disabling agoraphobia" and/or social phobias in approximately one third of their alcoholic inpatients.[30] An effort to replicate this observation revealed that 12 of 48 inpatients showed symptoms of agoraphobia, social phobias, or mixed phobias. Although the studies support the existence of these disorders in both male and female alcoholic samples, they do not separate out fully the developmental pattern except to suggest that the development of the phobic symptoms might precede that of alcoholism. This remains inconclusive, as it does for panic and generalized anxiety disorders that often seem to appear before alcoholism. Other complicating factors are the presence of affective symptoms in such patients, possibly representing major depressive episodes or premorbid depressive states. The ratio of females to males was 3:1 in Bowen's study; a higher ratio of females to males was found in Mullaney and Trippett's work. Quitkin and Rabkin reviewed the literature on panic disorders in alcoholic populations and stated that "panic disorder is more common in females than males; a middle-class adult female alcoholic population is most likely to contain covert cases of

panic disorder."

The current availability of pharmacological and behavioral therapies for panic disorder, agoraphobia, generalized anxiety syndromes, and social phobias is of particular importance to counselors. They must be prepared to diagnose these states in alcoholic women, **not mistaking anxiety, panic episodes, or dysphoric symptoms for early alcohol withdrawal states, and having the necessary period of time after detoxification to make a correct diagnosis, one which might well warrant the use of imipramine (Tofranil) and behavior therapy in conjunction with abstinence-oriented alcoholism treatment.** Unquestionably, this subtype falls under the auspices of psychiatry and will most often be diagnosed in a psychiatric setting.

Much of the above-reported literature contributes to the recognition that alcoholism often presents in conjunction with other discrete psychiatric conditions, particularly in hospital-based psychiatric treatment settings. Proper categorization of subgroups of women alcoholics is supported, as is the careful deliniation of associated causative psychological features and complicating symptoms that manifest themselves in many of these patients with other psychiatric syndromes.

Disruptive Family Behavior

It is clinically important to recognize the high incidence of disruptive family behavior as well as the deprivation that women alcoholics appear to experience even more than males. Such traumas as losing a parent through either divorce or death or growing up with alcoholic parents certainly must influence psychodynamic understanding and treatment approaches in such women. This is often compounded by the common occurrence of suffering with an alcoholic spouse or experiencing the

stress of divorce or separation at the time of initial assessment. As indicated earlier, women alcoholics report higher levels of anxiety, depressive mood, and severe family trauma—including unhappy childhoods, suicide attempts, and serious marital problems—including high rates of divorce and alcoholic spouses; all these stresses contribute to the development of depression or alcoholism.[9]

Psychodynamic Theories

POWER AND DEPENDENCY:

Although a few psychodynamic theories attempted to explain the development of alcoholism as related to conflicts over dependency and power, the research has predominantly centered on men. The **"dependency theory" in men presents the hypothesis that drinking gratifies dependency needs while permitting the drinker to maintain an appearance of independence and maturity. Furthermore, men are thought to drink more than women because of the stronger social sanction against overt expressions of dependency needs by men. Women alcoholics who seem to suit this model are seen as being unusually dependent or having much more restrictive opportunities for satisfying intense dependency needs.**

The other psychodynamic theory is related to feelings of "personal power over others." As men are seen to be more socialized in reference to their personal power concerns and are required by social pressure to display greater power, they may be more likely than women to need the temporary, though self-deceptive, feelings of power induced by alcohol. **Some studies indicate that, in both men and women, drinking may produce a mental state consistent with sex-role stereotypes and sex-role**

expectations. The offshoot of this is the model that explains women's drinking in terms of negative self-image and low self-esteem. A number of studies have determined that alcoholic women have lower self-esteem than either nonalcoholic women or alcoholic men. It is thought that **women might drink in order to experience the expectations about the generally positive effects of alcohol, in spite of alcohol's actual effects on them. If the net effect of drinking is to reduce rather than enhance feelings of adequacy and self-esteem, then potentially alcoholic women may, in the end, experience lower self-esteem, leading, in a vicious cycle, to increased drinking.**

SOCIAL EXPECTATIONS AND SEXUAL ROLES:

This feature of social and sex-role theory surrounds the question of serious conflicts about traditional feminine roles that problem drinking and alcoholic women may experience psychologically. These areas of conflict take two major forms: the first involves women who experience inconsistent sex-role attitudes and behaviors within their own personality; the second, less frequent, form involves women who are not internally conflicted about their sex-role orientation but who find themselves in stressful social environments that require stereotypic sex-role behavior. **Alcohol is presumed to influence sex-role conflicts by reducing tension or anxiety, blocking out conflicts related to sex-role performance, or enabling the individual to express sex-role attitudes and values by rejecting traditional feminine roles.** One study suggested that as many as 25% of alcoholic women experience internal psychological sex-role conflicts. However, the degree to which these sex-role conflicts interact with other biological and psychosocial factors in the development of alcohol abuse in women remains unclear.[1] **The pertinence of sex-role confusion or lack of feminine identification in alcoholism is not at all settled.** Attempts to delineate a female alcohol personality as a unique syndrome have thus far not been productive. Although the traits of poor self-concept and

low self-esteem appear prevalent in female alcoholics, other specific traits have not been identified by means of psychological testing.

The Treatment of Alcoholic Women

Over the past two decades numerous treatment programs began to consider the specific and sometime special aspects of the dynamics and concurrent treatment aspects for the alcoholic woman. Although the question is still unresolved as to whether alcoholism in women represents an unique clinical syndrome, some literature attempts to establish that there are specific treatment considerations for alcoholic women that must guide treatment programs as well as research efforts in this field. Gomberg has summarized a number of issues.[7] She suggests that one must always consider that there is still a stigma about alcoholism in women. She also notes that the research still regards alcoholic women as coming into treatment with fewer marketable skills, therefore needing greater emphasis on occupational or skills training.

Another aspect of treatment that bears emphasizing is that some form of conjoint therapy is usually indicated—with the spouse, parent, or other significant person in the social environment of the alcoholic woman. As some alcoholics are single or divorced, the treatment must often focus on teaching more effective coping and living skills, building social networks, and recognizing that alcoholic women must face special issues if they are parenting children.[7]

The two most likely motives that bring women into alcoholism treatment relate to their own health and their family problems. The high likelihood that alcoholic women have social and family problems requires all health professionals as well as those

involved in social and family services agencies to be particularly adept at assessing and referring potential clients for treatment.

The general treatment approach in alcoholism initially involves **educating both the patient and the family about the disease concept of alcoholism so as to reduce the stigma and the sense of guilt and overwhelming denial often inherent** in the alcoholic and those around her. The other notable feature of alcoholic women is **their propensity to abuse other psychoactive drugs.** Therefore any assessment must take this possibility into consideration. **Impulsive acts** (e.g. suicidal gestures) often complicate the initiation of treatment when detoxification is taking place, and hospitalization may be required.

Initial treatment always focuses on the practical aspects and techniques for achieving abstinence. Subsequent further evaluation of secondary or primary psychiatric problems should be considered, such as affective illness, family or marital disorders, and difficulties with children, including child abuse. A cluster of issues must be borne in mind when considering the dynamics of the alcoholic woman: **guilt as related to marriage and parenting functions; major deficits in self-esteem; severe social stigma; and an inability to express anger or assert oneself. A less directly confrontational and more supportive counseling approach seems indicated earlier in treatment than that usually advocated with male alcoholics. A minimum 30-day period of abstinence is necessary before any other psychiatric diagnosis might be made** (e.g. affective illness or panic-anxiety disorder). Major treatment issues during the first year of the recovery period revolve around building self-esteem; clarifying and resolving sex-role conflicts; settling specific marital and family problems, including concern with sexual issues and parenting problems; assertiveness training if indicated; and vocational training and rehabilitation.[4]

Other issues that need to be addressed during treatment are the management of dependency and improvement in interpersonal relationships. **The recovering woman patient should have a role model with whom she can easily identify; consequently, certain programs have advocated women-only therapy groups as well as a predominance of female staff providing treatment.** Still, **few empirical studies point to the approach that yields better results.** Some have suggested individual therapy may be more advantageous for women alcoholics than group therapy; there is, however, little in the literature to support this recommendation. However, some issues might best call for all-women patient groups, to permit them to deal with feelings and unresolved conflicts that center on sexuality, sexism, and particularly traumatic life events such as rape or childhood molestation. It is obvious that **the therapist must be aware of his or her own attitudes and beliefs as they affect relationships with women in general and in determining whether any member of the treatment team might have difficulty in dealing with some specific woman patient.**[31]

Although limited empirical data support the advantage of a woman therapist, programs often have established for themselves their own attitude about the empathy and positive female role model that the woman therapist might be able to provide in the early stages of treatment. However, one should also consider that **the therapist's own sex-role attitude and behavior may be as important an effect on treatment outcome as the actual gender of the therapist.** Many programs that work with large populations of women have established all-women therapy groups as well as mixed-gender groups so that issues at different stages in recovery might be addressed, depending upon the women's current ability to deal with sensitive topics as well as issues regarding their relationships with men. A particularly practical strategy, often not sufficiently addressed, is to provide some form of child care for alcoholic women who are also single

parents, since this is often reported to be one of the most obvious barriers to coming to treatment.[1]

It is well established that a significant subgroup of women alcoholics are married to male alcoholics; a serious source of insecurity derives from their financial and psychological dependence on such husbands. At the least, there should be an attempt at couples therapy to improve communication and understanding and, hopefully, to provide corrective experience for the serious interpersonal conflicts that have emerged during the course of the development of alcoholism in the woman. Family therapy has been receiving much recognition in the past two decades in the alcoholism field, particularly with the prominence given to the "family illness" concept. However, few studies establish the specific effectiveness of family treatment in alcoholism. Much serious consideration is now given to the total family system in the alcoholic marriage, and this must be addressed with any women alcoholic as it relates to her entering treatment and developing motivation for treatment.

Much of the work and the following recommendations are based principally on the literature about the male alcoholic's marriage. A central feature of the alcoholic's family is "denial," which is seen as the defense protecting the alcoholic as well as the family from early recognition of the actual, severe distress associated with uncontrolled pathological drinking patterns and all the accompanying biopsychosocial sequelae. It is noteworthy that it is not only the alcoholic who is denying the condition, but also the spouse and other family members. In assessing family members who are married to or living with an alcoholic patient, it is important to recognize which psychological issues and overt behaviors might be contributing to protecting and supporting the continuation of the alcoholic drinking in the family.

Family sessions that provide for confrontation of the alcoholic by the family in a rational, calm, organized manner very often provide for the kind of intervention that leads to treatment. It is recognized that all members of the family are under considerable stress; yet pressure must be generated, and it must be hopeful and supportive to effect insight and initiation of treatment.

In assessing the alcoholic family and the marriage of the alcoholic, several questions should be raised that relate to the effects of the drinking problems on the marriage and the family itself. What role did alcohol play in the early stages of the marriage? Did the alcoholism or drinking problems predate the marriage, or did they develop subsequently? Did certain stresses develop during the course of the marriage and contribute to the drinking or reinforce it once it was established? It is especially important to determine whether the alcoholic's drinking predated the marriage, in which case the couple and the family may have never had positive experiences of communicating in a meaningful, constructive manner. In all alcoholic families, there is a varying degree of tension associated with the unpredictable nature of the alcoholic and his or her effect on the family. Communications research has indicated that ineffective transmission of information—particularly as it relates to emotions—is common, whether verbal or nonverbal. It is important to examine the effectiveness and efficiency of communicational exchanges and patterns in alcoholic couples: partners are usually unable to express their feelings, wishes, or opinions such that the other partner responds in an appropriate manner.

Other areas that require focus are assessment of conflicts over control, dominance, or dependence. Treatment approaches often center on problem-solving exercises and the behaviors that have tended in the past to diminish or undermine the effectiveness of

the partnership or the family. **Another critical area in family treatment is that of the degree of pleasurable, positive experiences the family has developed without alcohol being a factor. Three major techniques are often used in teaching couples more effective communication and problem-solving skills. These involve feedback, modeling, and behavioral rehearsal.**[32]

Outcome of Alcoholism Treatment in Women

Most studies currently available in the literature do not adequately distinguish between the outcome rates for women as compared with men alcoholics. Many of the studies to date do not even include adequate samples of women; others claim no gender differences in the outcome rates. A few studies that have reported gender differences indicate a **slightly better outcome for men than for women.** In addition, a great number of methodologic problems exist in most of the literature; therefore, any comparison of heterogeneous samples of alcoholic women and men are not particularly useful. If, as indicated in some of the studies, alcoholism treatment may be less effective for women than for men, it may reflect some bias regarding the antecedents and consequences of alcoholism in men versus women. Available reviews have raised a number of clinically significant issues that have not been sufficiently empirically researched to date. However, consideration must always be given to the question of alcoholic women subtypes: does the presence of an affective disorder or another concomitant psychiatric condition affect outcome? In alcoholism with depression, **the effective use of antidepressants when indicated** could have a significant influence.

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QUESTIONS BASED ON THIS LESSON:

9. Which of the following statements is correct?

   A. Female adolescents have significantly decreased alcohol consumption during the past two decades

   B. The male-female ratio of alcoholism in outpatient clinics and state hospitals is about 1:1

   C. The male-female ratio of alcoholism in outpatient clinics is about 4:1 vs. a much lower ratio in private facilities

   D. The predominant understanding of alcoholism is based on studies of female alcoholism

10. Which of the following statements is correct?

   A. Physicians commonly prescribe antianxiety drugs to relieve stress-related symp toms in women, even alcoholics

   B. The risk of drug dependency is minimal in alcoholic women

   C. A history of childhood sex abuse is rare in female alcoholics

   D. Stressful events rarely contribute to the onset of serious drinking in female alcoholics

11. Which of the following statements is correct?

A. About 25% of women alcoholics are also diagnosed as antisocial or sociopathic vs. only 8% for male alcoholics

B. The alcoholic woman who is also sociopathic reveals a poorer prognosis and an earlier onset of drinking

C. Coexistent drug abuse problems are rare in sociopathic female alcoholics

D. A diagnosis of alcoholism in women precludes the likelihood of a coexisting diagnosis of panic disorder or borderline disorder

12. In contrast to men, women seem to:

A. Find alcohol less effective in reducing anxiety

B. Never use minor tranquillizers in combination with alcohol to cope with stress

C. Report a more negative, unpleasant affect as a consequence of drinking

D. Have a later-in-life onset and more rapid acceleration of their drinking problems

Directions in Rehabilitation Counseling

VOLUME 3 • LESSON 4

Advances in the Treatment of Anxiety Disorders: A Therapist's Guide

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EDITOR'S NOTE

Anxiety disorders constitute the most common group of mental and emotional disorders seen in the United States. They affect about 19.5% of women and 8% of men in their lifetimes. About 25% of people with anxiety disorders also suffer with substance abuse; about 21% have concomitant affective disorders.

Six major syndromes are noted: panic disorder with or without agoraphobia; simple phobias, like fear of flying; social phobias such as fear of public speaking or social gatherings; obsessive-compulsive disorder; post-traumatic stress disorder; and generalized anxiety disorder.

Treatment basically consists of (a) cognitive, (b) behavioral, and (c) pharmacologic approaches, although other forms of therapy, including individual and group psychotherapy have a place. Cognitive therapy aims to change the way the client experiences his or her fears, whereas behavioral therapy is directed at overcoming avoidance, often the most disabling part of the condition. Pharmacologic treatments include the antidepressants, which are frequently effective when used appropriately over time, and benzodiazepines, which, in spite of their potential to produce side-effects, are especially effective in relieving anxiety symptoms on an ad hoc basis. Even though for some clients psychological approaches alone are sufficient, for many others psychotherapy should be effectively integrated with pharmacologic treatment.

Introduction

This lesson reviews recent advances in the knowledge of anxiety disorders and offers treatment guidelines for therapists. Because many anxious clients are being treated by nonphysician therapists, and because many physicians remain poorly informed about the treatment of these conditions, there are many opportunities for all therapists to improve their treatment strategies and to educate one another on how best to treat anxious clients.

Anxiety—from *anxius*, the Latin word for agitation or distress—is the body's mechanism to warn of danger. Anxiety is experienced simultaneously in behavioral, physiological, and cognitive manifestations. Behavioral signs involve escape or avoidance. Physiological elements include symptoms that cause acute distress and fuel the urge to escape immediately. Cognitive involvement occurs on several levels: evaluation of danger symptoms, evaluation of escape routes, and evaluation of future avoidance strategies to prevent or reduce distress. Imagining terrifying possibilities in the immediate future is a major cognitive element of the fight-or-flight response to perceived danger. Images of danger can be external (an automobile crash) or internal (a heart attack). All three manifestations must be addressed in the treatment of the anxious client.[1]

When anxiety signals danger inappropriately, it causes additional distress as sufferers worry about the physical harm this "stress" may cause. They often feel guilty because they believe, as do many nonanxious people, that they should be able to cope with their problems like "normal" people without reliance on therapy or medicines. This lesson focuses not on everyday anxiety, a useful and common emo-

tion, but on clinically significant anxiety, which is often extreme and crippling and which causes distress and disability.

The Clinically Anxious Person

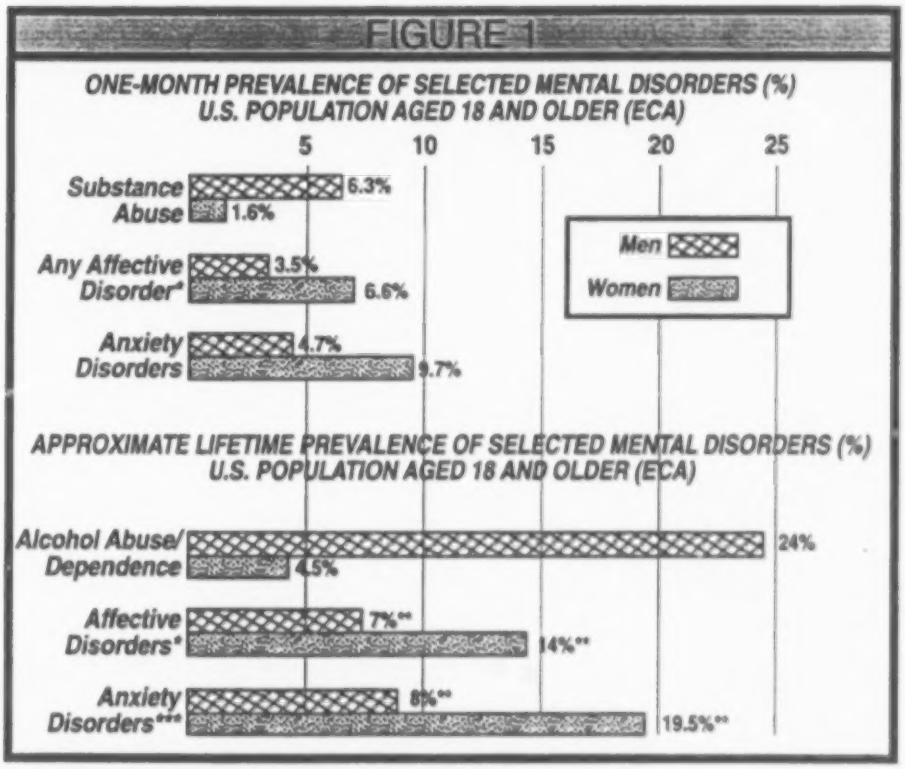
People with anxiety disorders suffer from excessive worry and tension that they know is abnormal and inappropriate. They have a malignant disease of the "what ifs," a morbid fear of impending imagined dangers. **They tend to be perfectionistic and eager to please as well as sensitive to criticism. Many of them fear medicines and have concluded they are unusually sensitive to all medications, based on frightening reactions to previously used medicines.** The anxiety disorders **tend to be familial,** although the specific genetic link remains a mystery. These disorders are **usually lifelong with a waxing and waning course. Many upsurges of symptoms are related to stressful life experiences, but anxiety can increase at times of relatively low stress for no apparent reason.**

Many of the anxiety disorders are characterized by **a vicious cycle of panic, anticipatory anxiety, and avoidance.** Much of the distress results from the panic and anticipatory anxiety, whereas much of the disability results from the avoidance. Treatments seek to break this pathogenic cycle. **Pharmacologic treatments focus on the first fear, panic. Cognitive therapies focus on the second fear, anticipatory anxiety. Behavioral treatments focus on avoidance.** If any of these links is reduced, the cycle is slowed, and life is made more manageable and more bearable.

The Epidemiology of Anxiety Disorders

The anxiety disorders are the most common mental disorders in the United States, affecting **19.5% of women and 8% of men in their lifetimes. The 6-month prevalence is 9.7% for women and 4.7% for men** (see Figures 1 and 2). Those

FIGURE 1



* Includes major depressive episode, dysthymia, manic episode.

** Numbers are elevated slightly because persons with multiple diagnoses are counted more than once.

*** Includes panic disorder, agoraphobia, obsessive-compulsive disorder, simple phobia. Does not include social phobia, generalized disorder, post-traumatic stress disorder, or adjustment disorder with anxious mood.

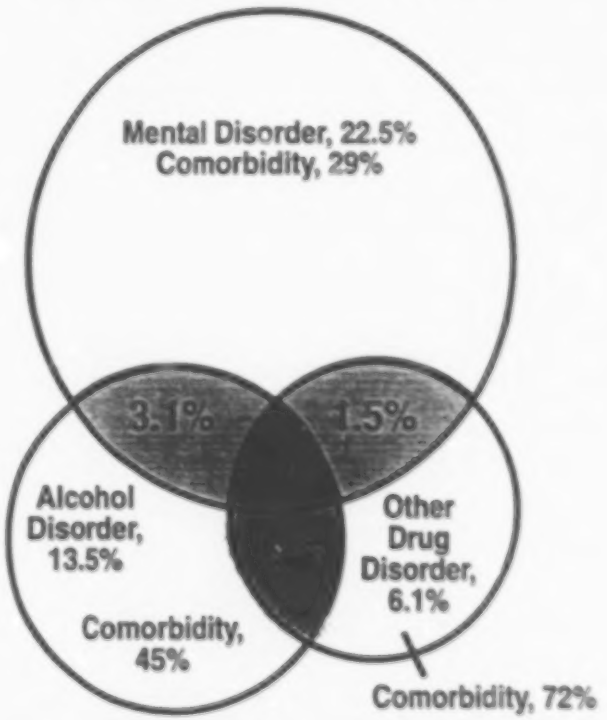
Adapted from Robbins et al. Copyright 1994, American Medical Association.

McGlynn TJ and Metcalf HL, Eds. *Diagnosis and Treatment of Anxiety Disorders: A Physician's Handbook.* Washington, DC: American Psychiatric Press Inc; 1989.

FIGURE 2

LIFETIME PREVALENCE OF COMORBID MENTAL AND ADDICTIVE DISORDERS

Combined community and institutional
five-state epidemiologic catchment area data
standardized to the U.S. population



Source: Regier DA, Farmer ME, Rae DS, et al. Comorbidity of mental disorders with alcohol and other drug abuse. *JAMA*. 1990;264:2511–2518.

data—based on households, not on people receiving treatment—are from the Epidemiological Catchment Area (ECA) study of the National Institute of Mental Health (NIMH), which is providing new understanding about the incidence and prevalence of all mental disorders.[2] **The anxiety disorders share with the affective disorders a roughly two-to-one preponderance of females and are most common in middle age.** Surprisingly, **the prevalence of anxiety disorders is inversely related to social class, occurring at nearly double the rate in the lowest socioeconomic class** compared with the highest grouping.

The gender ratio of the anxiety and affective disorders contrasts with the substance use disorders, the second most prevalent group of mental disorders. Substance use disorders are most highly concentrated in young adults (under the age of 30), with a roughly 1 to 4 female-male ratio. **About one quarter of all people with anxiety disorders are comorbid for substance use disorder, and 21% are comorbid for an affective disorder; 33% of those with an affective disorder also have an anxiety disorder. Once alcoholics are sober they are no more likely than the general population to suffer from an anxiety disorder.[3]**

Although population studies are useful in assessing the magnitude of particular clinical problems in the population as a whole (and within specific subgroupings of the population), these studies can be dangerously misleading because they tend to reinforce stereotypes that blind clinicians to important problems of their clients. These new data from the ECA study are no exception. Although it is true that more women than men suffer from anxiety disorders and more men than women suffer from substance use disorders, the clinically more useful point is that these are two widely distributed groups of disorders that have high prevalence rates across ages, sexes, and social classes. **Clinicians need a high level of sensitivity to both anxiety disorders**

and substance use disorders among *all* of their clients, including those suffering from other physical and mental illnesses. Making an accurate diagnosis is the first step toward specific and effective treatment.

The Classification of Anxiety Disorders

Six major syndromes are classified under the anxiety disorders in the *Diagnostic and Statistical Manual of Mental Disorders*, Third Edition, Revised (DSM-III-R).[4]

PANIC DISORDER WITH AND WITHOUT AGORAPHOBIA:

Panic attacks are acute, overwhelming episodes of anxiety with sympathetic nervous system activation commonly associated with fear of dying, going crazy, or losing control. Agoraphobia is the syndrome of "adult separation anxiety," the fear of being away from a safe person or safe place. It is typically associated with panic attacks that are often spontaneous at the onset of the illness but that over several years become predominantly situational. Situational panic attacks predictably occur for each sufferer at times when panic attacks are perceived as dangerous or embarrassing.

SIMPLE PHOBIA:

Situational anxiety, usually particular and predictable experiences such as fear of flying or fear of closed spaces, is characteristic of a simple phobia. Spontaneous panic is lacking. Most simple phobia clients usually do not have intense autonomic discharges in phobic situations. Like all anxiety disorders, the effects of

the symptoms of simple phobia on the clients' lives can be relatively minor if the avoidance is not significant, or they can be profoundly crippling if the clients are preoccupied with the fears and/or if the avoidance leads to major limitations in the clients' lives.

SOCIAL PHOBIA:

Social phobia is a morbid fear of critical evaluation by others and of humiliation and embarrassment. The most common manifestation is fear of public speaking, which is not usually associated with a generalized shyness and social inhibition. Clients who fear public speaking generally have the necessary speaking skills but are unreasonably critical of themselves. They suffer from sweating and rapid heart rate when they begin to speak and from anticipatory fear of giving a speech. Pervasive shyness describes another major social phobia group. Severe shyness can limit schooling, vocational performance, and social interactions, including friendships and marriage. Other common forms of social phobia include fear of eating or writing in front of others, fear of using public restrooms, and fear of crowds or large social gatherings.

OBSESSIVE-COMPULSIVE DISORDER (OCD):

Obsessions are repeated, unwanted repugnant thoughts; compulsions are rituals engaged in to reduce the painful anxiety caused by obsessions. Clients with OCD often hide their symptoms—even from their therapists—because they find them bizarre and humiliating. Obsessions and compulsions may consume many hours each day, leaving clients only when they sleep.

POST-TRAUMATIC STRESS DISORDER (PTSD):

PTSD is a syndrome characterized by panic, anxiety, nightmares, flashbacks, and depression, and it is often accompanied by avoidance and substance abuse. PTSD follows an overwhelming stress, such as combat, an assault, or a severe fire. Flashbacks and nightmares in which the person relives the initial traumatic experience are common.

GENERALIZED ANXIETY DISORDER (GAD):

GAD is a disorder with hallmark symptoms of **excessive or unreasonable worries that last at least 6 months and focus on one or more life circumstances, usually health, finances, safety, or occupation.** Clients who have GAD worry about the occurrence of bad outcomes and spend hours in nervous rumination or anxious dread of a feared outcome. When GAD clients are nervous or anxious, somatic and psychic symptoms develop and can become debilitating. Symptoms wax and wane in conjunction with specific worries.

Diagnosing Anxiety Disorders

The boundaries separating the individual anxiety disorders are often blurred, but a diagnosis of one of the specific syndromes is made when features of that disorder dominate the clinical picture. Several anxiety disorders may be present at the same time. Similarly, some anxious clients are comorbid for affective, substance use, and personality disorders. The primary diagnosis is the one that dominates the clinical picture, and it is often the part of the client's illness that appeared first. Recovery from any of the anxiety disorders requires a comprehensive treatment plan

that addresses physiological manifestations of anxiety, behavioral avoidance, and cognitive factors such as negative self-talk.

Psychological Treatments

Psychological therapy is the cornerstone of the treatment of anxiety disorders,[5] and **cognitive-behavioral treatment is the treatment of choice for anxiety-disordered clients. Cognitive therapy helps clients think about their illnesses in new ways that promote recovery. Behavior therapy teaches clients to enter feared situations using specific exposure techniques.** These strategies diminish symptoms of panic and anxiety, although the exact mechanisms of symptom relief are poorly understood. Together, cognitive and behavioral techniques help to diminish the frequency and nature of worries and reduce the number and intensity of symptoms related to worry, panic, and phobic avoidance. The approach teaches clients that their symptoms, although distressing, are not harmful.[6]

COGNITIVE THERAPY:

Cognitive therapy for anxiety disorders focuses on a client's internal monologue. A primary strategy engages client and therapist in **a collaborative evaluation of the client's automatic self-talk,** which may occur quickly and may not be experienced as a conversation with oneself. **Identifying dysfunctional cognitions, themes, or styles of thinking can help the anxiety-disordered client understand how internal evaluation about anxiety symptoms and internal self-critical thinking styles perpetuate the vicious anxiety cycle.[7] Typical cognitive themes found in anxiety-disordered clients show inappropriate demanding, perfectionistic, self-denigrat-**

ing, and catastrophic statements. It is also common for anxiety clients to make conclusions based on a feeling and then to make predictions about future recovery based on the same feeling. This often leads to hopelessness and more anxiety. Cognitive therapy restructures or reframes dysfunctional thinking patterns and helps clients generate and test more realistic hypotheses that challenge their original destructive conclusions. Clients can learn that they can influence feelings by thinking in new ways, which becomes a powerful way to support further beneficial change.

BEHAVIOR THERAPY:

Behavior therapy for anxiety disorders has two main strategies: applied relaxation and in-vivo (real-life) exposure.[1,8] Applied relaxation refers to a technique of rapid relaxation in an anxiety-provoking situation. This technique is taught by the therapist and practiced until the client achieves mastery. Rapid relaxation techniques include diaphragmatic breathing, awareness of muscle tension, and imagery components.

In-vivo exposure is a process of gradual and repeated presentation of a feared situation or a feared feeling. Based on Wolpe's systematic desensitization, the technique is applied in the natural environment instead of the therapist's office. It involves exposure in successive steps to the feared situation, coupled with coping statements, anxiety ratings, and therapist-guided modeling and assistance. It is important to individualize this approach in order to address the specific feared situation and the client's fear-related cognitions. A hierarchy of feared situations is developed at the beginning of therapy. After training in behavioral and cognitive anxiety management skills in the therapist's office, the client and therapist apply these skills in situations initially at the lower end of the client's hierarchy. As the client's

anxiety decreases, situations higher on the fear hierarchy become easier to address. The techniques of behavior therapy are specific and can be applied in all feared situations.[9] The art in applying these strategies, however, requires creativity and resourcefulness as well as persistence.

COGNITIVE PLUS BEHAVIORAL THERAPY:

Combined cognitive and behavioral techniques address all three anxiety components—behavior, thought, and physiology. Treatment is a goal-oriented active process that includes office sessions and out-of-office exposure. Clients are actively involved in reading, self-monitoring, and practice assignments. Family members or friends may be asked to participate in exposure practice. Careful records of progress should be maintained in order to follow change from baseline ratings at the beginning of therapy. This reinforces the client's sense of accomplishment and builds a positive momentum for healthy change.

OTHER PSYCHOLOGICAL TREATMENTS:

A variety of other less specific treatments helps some anxious clients. **Traditional individual, family, and group psychotherapy have useful roles in coping with painful past experiences and difficult current relationships. Some anxious clients benefit from stress management training and assertiveness training. Many anxious clients are helped by avoiding caffeine** (a stimulant that can precipitate panic and anxiety) **and alcohol** (a depressant that initially reduces anxiety but that stimulates anxiety when the acute effects wear off). It is always useful to consider **lifestyle factors** (i.e., work habits, diet, substance use, exercise, smoking) when

developing an anxiety treatment plan.[10]

Increasingly, anxious clients are finding help through **mutual-aid programs**, some of which are modeled on the original Alcoholics Anonymous (AA) 12-step fellowships.[11] The rapidly expanding list of options for self-help include Emotions Anonymous (EA) International Services, P.O. Box 4245, St. Paul, MN 55104, telephone (612) 647-9712; Phobics Anonymous (PA) World Service Headquarters, P.O. Box 1180, Palm Springs, CA 92263, telephone (619) 322-COPE; and Recovery, Inc., 802 N. Dearborn St., Chicago, IL 60610. The books of Claire Weekes, M.D., an Australian general practitioner and a pioneer in the cognitive-behavioral treatment of anxiety disorders, have been particularly helpful to many sufferers and to their families.[12-14]

Pharmacologic Treatments

The growing recognition of biological factors in anxiety disorders has heightened the interest in pharmacotherapy for such conditions.[15] Many factors control the response of any particular client to the available treatments, so treatment professionals should search for the best way to help each client lead a normal life. Medications can be a useful addition to the psychological strategies discussed previously. For example, **combined treatment with imipramine (Tofranil) and exposure therapy can be more effective than either used alone for treating panic disorder with agoraphobia.**[16] Abundant clinical experience supports other combined approaches to treatment, particularly with **benzodiazepines, monoamine oxidase inhibitors (MAOIs), and newer drugs that block serotonin reuptake**. Some clients do well with medicines, whereas others do well with nonmedical treatments. Many anxious clients benefit from combining medicines with psychological treatments.[17] The two major classes of medicines used to treat the anxiety disorders are the benzodiazepines and the antidepressants.[18]

THE BENZODIAZEPINES

Names Trade (Generic)	Usual Maximum Dose/Day (mg)	Onset*	Elimination Half-life	Metabolism**
Commonly used in daytime for anxiety:				
XANAX (alprazolam)	4	M	8 hrs.	O
VALIUM (diazepam)	40	F	48 hrs.	O
ATIVAN (lorazepam)	10	M	12 hrs.	C
SERAX (oxazepam)	60	S	12 hrs.	C
TRANXENE (clorazepate)	15	M	48 hrs.	O
LIBRIUM (chlordiazepoxide)	40	M	48 hrs.	O
KLONOPIN (clonazepam)	2	M	48 hrs.	O
Commonly used for insomnia:				
HALCION (triazolam)	0.25	F	4 hrs.	C
RESTORIL (temazepam)	30	S	12 hrs.	C
DALMANE (flurazepam)	30	F	72 hrs.	O
DORAL (quazepam)	15	F	36 hrs.	O
PROSOM (estazolam)	2	M	12 hrs.	O

* Time after oral dose for effect: S = slow; M = medium; F = fast

** Metabolism: O = oxidation by liver microsomal enzyme
C = conjunction

Source: DuPont RL. Choosing the right treatment for the patient with anxiety. Accepted for publication in *Modern Medicine*.

BENZODIAZEPINES:

The benzodiazepines (see table opposite) **are rapidly effective in reducing anxiety after a single dose**. They can be used on an as-needed basis by anxious clients, who take a benzodiazepine before a potentially upsetting experience, or they can be used several times each day. These same medicines are effective in the treatment of insomnia, the syndrome of worry about sleeplessness. The benzodiazepines are specific "antiworry pills." **However, they are occasionally abused by alcoholics and drug addicts, and they can be difficult to discontinue after many months of everyday use.**

Alprazolam (Xanax) is the most commonly used benzodiazepine in the United States today. **A typical antianxiety dose is 0.25 mg or 0.5 mg, which can be used occasionally or three or four times a day**. Sometimes higher dosages, occasionally as much as 6–10 mg a day, are needed to stop panic attacks. **With long-term treatment, clients who were not previously addicted to alcohol or other nonmedical drugs do not usually escalate their benzodiazepine intake.** Even in the treatment of panic attack, most clients find they do well on lower doses once their panic attacks have been brought under control for several months.

Poor response to a benzodiazepine and dose escalation above the usual over time often signal a preexisting substance use disorder and is an indication for stopping the drug. When stopping a benzodiazepine or other medicines that have been taken every day for many months, gradual withdrawal over several weeks or even longer is advisable to reduce discontinuation problems. Because the benzodiazepines are effective antiseizure medicines, they should be tapered gradually after prolonged everyday use to prevent rebound seizures, even in clients with no prior seizure history.

ANTIDEPRESSANTS:

In addition to treating depression if it coexists with anxiety disorders, antidepressants also suppress panic attacks and show a broad anxiolytic effect.[19] **Unlike the benzodiazepines, antidepressants are usually taken once a day and produce their beneficial effects only after 3 or 4 weeks of continuous daily dosing. Fluoxetine (Prozac) is the most widely used antidepressant in the United States today.** It is typically used at once-daily dosages of 20 mg to treat panic attacks and generalized anxiety.

Antidepressants cause more side effects than the benzodiazepines, but they are not abused by alcoholics and drug abusers, and withdrawal is usually easier after everyday use. **Antidepressants are harder to take than benzodiazepines but are easier to stop. Also, antidepressants cannot be used on an as-needed basis: they must be taken every day for many months.** Some antidepressants, particularly amitriptyline (Elavil) and trazodone (Desyrel), are relatively sedating and are occasionally used as sleep aids.

The serotonergic antidepressants, fluoxetine and clomipramine (Anafranil), are specifically effective in the treatment of obsessive-compulsive disorder. Typical dosages for fluoxetine to treat OCD are as much as 80 mg a day, and for clomipramine up to 250 mg a day. The antiobsessional effects are fairly subtle at first and often do not start until after 4 weeks of everyday treatment. **Benefits of treatment for OCD may not peak until 10 or 12 weeks have passed.** As in the use of other antidepressants, **dosages should be increased gradually to get full benefit, because side effects are common early in treatment. The most common side effects of fluoxetine are fatigue and insomnia,** although most clients experience no

side effects from this medicine. Its side-effects profile is in strong contrast to that of the other antidepressants, for which side effects, including dry mouth and constipation, are much more common. Most of the antidepressants can cause reduction in sexual interest and potency; many, except fluoxetine, can also cause weight gain.

The benzodiazepines can be used with antidepressants, although both can cause sedation initially. For this reason, driving or operating dangerous machinery should be performed with caution when treatment is instituted with either benzodiazepines or antidepressants. Both antidepressants and benzodiazepines can cause excessive sedation when used along with alcohol; therefore, drinking alcohol is generally discouraged while taking either type of medicine.

OTHER ANXIOLYTICS:

Propranolol (Inderal) is useful specifically in the treatment of public speaking phobia. A 20–40 mg dose taken 1 or 2 hours before a speech lasts about 4–6 hours. Buspirone (BuSpar) may be useful in the treatment of generalized anxiety disorder, especially for clients who have not used a benzodiazepine, for those with an active chemical dependency, and for the elderly. Like the antidepressants, buspirone must be taken every day (often at dosages of 5–10 mg three or four times a day) for several weeks before the effects occur. The effects of buspirone are likely to be subtle, prompting many physicians—and their clients—to doubt its effectiveness. Clients who have previously used a benzodiazepine do not like buspirone because it lacks antianxiety relief. Buspirone does not produce mood elevation, so it is not abused by chemically dependent people and is not considered a controlled substance by the Drug Enforcement Administration (DEA). Elderly people with anxiety

disorders are especially sensitive to the potentially sedating effects of benzodiazepines and antidepressants. Therefore, they are good candidates for buspirone, which is not sedating.

The Dual-Diagnosis Client

About one quarter of clients with anxiety disorders have concomitant substance use disorders. **When they are actively drinking and using other drugs nonmedically, their anxiety disorders cannot be treated successfully by either psychological or pharmacologic means, and it is impossible to make a reliable diagnosis other than substance abuse.** While using drugs, many active substance abusers show a bewildering array of symptoms of serious mental illness, ranging from paranoid schizophrenia and manic-depressive illness to depression and the specific anxiety syndromes. Once chemically dependent people have stopped nonmedical drug use and join a recovery program, the symptoms of other mental illnesses often disappear.

A reliable diagnosis other than substance abuse disorder cannot be made until the client has had at least 6 months of sobriety. Chemically dependent clients who continue to use drugs nonmedically and/or drink alcohol usually should not be treated with any controlled substance on an outpatient basis, including a benzodiazepine, because of the risk that such medicines will become part of the substance abuse problem. Substance abusing clients should be encouraged to enter formal chemical dependence treatment, often a 28-day inpatient treatment program, and then regularly attend meetings of Alcoholics Anonymous (AA), Narcotics Anonymous (NA), or similar 12-step fellowship for many years or a lifetime. Family members should be encouraged to join Al-Anon.

Anxiety-disordered-clients who have a stable, long-term recovery from substance abuse are a special case in terms of pharmacologic treatments. Generally, they should not be given benzodiazepines on an outpatient basis, but they **can use the antidepressants and the other noncontrolled prescription medicines that treat specific anxiety disorders.** On the other hand, many recovering people do well with benzodiazepines and show no tendency to relapse.[20] Benzodiazepines should be used only by recovering people with anxiety disorders who have a solid therapist-client relationship and a spouse or other family member as well as an AA sponsor who are fully informed and participating in the treatment. Attention to the potential for relapse must be maintained.

Integration of Psychological and Pharmacologic Treatments

Suffering caused by the anxiety disorders is often intense, and the disabilities experienced by anxiety-disordered clients can be profound. Clients should be encouraged to select from available treatments the ones that are best suited to their needs. **The goal of treatment is to help the client lead a full, normal life without restriction because of the anxiety disorder.** Clients who use medicines do not lose their desire to work in psychological treatments, nor do medicines reduce the effectiveness of such therapies. On the other hand, many clients who are active in psychological treatments, even when they benefit greatly from them, remain symptomatic from their anxiety disorders and can often benefit from the use of appropriate medicines.

Nonphysician therapists can team up with physicians who are familiar with the psychological and pharmacologic treatments of the anxiety disorders and

offer their clients a full range of treatment options. So, too, can physicians work with expert therapists to offer their clients a full range of modern treatments. It is quite reasonable to try nonpharmacologic means first. If the clients' symptoms are so severe that they cannot benefit from psychological treatments, or if they have used psychological treatments and remain distressed by their illness, then medicines are usually appropriate. Similarly, **clients treated—even successfully treated—with medicines often need psychological treatments to resume the normal behaviors that they have avoided** because of their anxiety disorders.

Many factors are important in selecting specific treatments for each anxious client, including the preferences of both the client and the therapist. **The selection of treatments is not a high-stakes gamble that must be correct the first time:** there is no right treatment and no wrong treatment for all clients. The contemporary treatment of anxiety disorders is a matter of an educated process of trial and error as the therapist and the client work together to find the most effective approach to improving the quality of the client's life. If one approach does not produce the desired results, then another must be tried. There are many good alternative psychological and alternative pharmacologic choices. With skill and persistence the large majority of clinically anxious clients can now be helped to lead normal lives reasonably free of disability and distress. That hope can inspire the client-therapist collaboration, even during difficult episodes in the treatment process.

Clients with anxiety disorders also have the full range of human problems, many of which can benefit from various psychological treatments. Often anxious clients are only able to work on those problems in therapy once the acute distress of their disorder has been successfully treated (with or without medication).

Summary

The anxiety disorders are the most widespread mental illness in the United States. Although often distressing and crippling, they can be helped through both psychological and pharmacologic treatments, many of which are relatively new. The cognitive-behavioral treatments dominate the psychological treatment picture, and benzodiazepines and antidepressants are preeminent in the pharmacologic approach to treatment of these disorders. Treatments can be successfully integrated, and nonphysician therapists and physicians can work together to offer a full range of effective modalities for their anxious clients.

Further information about the nature and treatment of anxiety disorders can be obtained from the following:

Anxiety Disorders Association
of America (ADAA)
6000 Executive Boulevard
Suite 200
Rockville, MD 20852

Tel: (301) 231-9350

Obsessive-Compulsive Disorder
Foundation, Inc.
P.O. Box 60
Vernon, CT 06006

National Anxiety Foundation
3135 Custer Drive
Lexington, KY 40501-4001

Tel: (606) 272-7166

National Institute of Mental Health
Public Inquiries
5600 Fishers Lane—Room 15C05
Rockville, MD 20857

Tel: (301) 443-4515

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Questions Based on This Lesson

13. Anxiety disorders:
    A. Affect only about 8% of women versus 19.5% of men
    B. Occur in association with affective disorders about 21% of the time
    C. Never occur in association with substance abuse disorders
    D. Do not tend to run in families

14. Someone suffering with a fear of public speaking may be considered as having which of the following forms of anxiety disorder:
    A. Panic disorder with and without agoraphobia
    B. Simple phobia
    C. Social phobia
    D. Generalized anxiety disorder

15. Which of the following statements regarding the treatment of individuals with anxiety disorders is correct?
    A. Cognitive therapy teaches clients to enter feared situations using specific exposure techniques
    B. Behavioral therapy helps clients think about their illnesses in new ways that promote recovery
    C. Applied relaxation is used to reduce inappropriate demanding, perfectionistic, self-denigrating, and catastrophic cognitive themes
    D. In-vivo exposure involves encouraging the client to confront, in successive steps, the feared situation, under careful therapeutic supervision

16. In using pharmacological methods to treat people with anxiety disorders:

A. Antidepressants are useful to significantly alleviate distress in clients with anxiety disorders even when coexitent clinical depression is not present

B. Benzodiazepines present no problems, even in clients with histories of serious substance abuse

C. Antidepressants are best used on an ad-hoc basis to quickly relieve the distress associated with anxiety attacks

D. It is always possible to avoid psychological therapy altogether, thus reducing the financial cost of treatment

Directions in Rehabilitation Counseling

VOLUME 3 • LESSON 5

Rehabilitation Counseling with the Criminal Offender in the Community Setting

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EDITOR'S NOTE

In this lesson, the author describes some of the very special and often very difficult aspects of serving as a counselor within the criminal justice system. To be effective, such counselors must understand how offenders experience life, which emotional states, attitudes, values and defense mechanisms determine offenders' perceptions and reactions to the outside world, and how the outside world treats the offender. Coordination and follow-up of services are essential. Since substance abuse is common among offenders, counselors should be quite familiar with the recognition and management of these problems.

Various theories of criminal behavior are presented, along with a detailed description of what passage through the criminal system is like, including incarceration and the special stresses that offenders are faced with under such conditions. When serving as parole or probation officers, counselors have a particularly fine line to walk, since they are at one and the same time attending to offenders' psychological and social needs and also policing their behavior.

The author highlights specific counseling techniques used to attack known characteristics among various types of criminals. Counselors will also be called on to work with crime victims, requiring them to be skilled in managing grief reactions and post-traumatic stress disorders, as well as other emotional sequellae of victimization.

Introduction

Rehabilitation counselors are employed throughout the adult criminal justice system (CJS) and associated service providers. The philosophy and training of rehabilitation counselors make them uniquely appropriate for working with the adult offender. **Many offenders are vocationally dysfunctional and have one or more disabling conditions.** Simply being in the CJS is vocationally and emotionally limiting. **The basis of rehabilitation counseling is the promotion of self-reliance, self-commitment, self-motivation, and personal integrity, qualities found seriously lacking in most offenders and nearly all repeat offenders.** In addition, most adult offenders are underemployed, undereducated, and without skills needed to live a productive life within the mainstream of society.

In order to work with the adult offender, **the rehabilitation counselor must be aware of the dynamics that lead to criminal behavior and the conditions to which the offender is exposed in the CJS,** particularly incarceration and correctional supervision. Being an effective counselor of offenders requires understanding **how offenders experience life; which emotional states, attitudes, values, and defense mechanisms determine offenders' perceptions and reactions to the outside world; as well as how the outside world actually treats offenders.**

For a counseling approach to be useful in working with adult offenders, it must aid in gaining adult offenders' trust, sharing their internal experiences, and confronting destructive attitudes and behaviors. Once adult offenders decide to cooperate in change, an approach is needed to help them acquire skills that enhance their ability to avoid further involvement in criminal behavior and to become self-supporting.

To work holistically with adults who are in the CJS is to call on a wide range of service providers and institutions that can aid adult offenders and control their behaviors (not always to the ultimate advantage of the adult offenders or the community). **Coordination and follow-up of these services are important because of their**

many needs and a history of repeated service delivery failures for the adult offender. Because of the overrepresentation of many minority groups in the CJS, particularly in the prison system, **cultural awareness and sensitivity** are helpful in engaging adult offenders who might react negatively to actual or imagined stereotyping and rejection by the counselor. **Gender sensitivity** is required because of the **high incidence of men dominating and victimizing female offenders**, who have poor self-esteem and limited problem-solving abilities in male-female relationships.

The **high risk of drug and alcohol abuse** among adult offenders demands special attention. Drug abuse, which is a crime in itself, is associated with a wide range of criminal activity. Many assaultive crimes involve intoxicated perpetrator and victim, and many offenders report money for drugs as the motivation for property offenses. Substance abuse limits the adult offender's ability to make sound judgments, to stabilize their lifestyle, and to succeed in rehabilitation programs.

Victims are an important part of the rehabilitation counseling process for several reasons. Most crimes involve victims. Even so-called victimless crimes, such as illicit drug sales, ultimately create victims. In the CJS, adult offenders are assigned the role of repenter and payer of restitution to the victim. **Although restitution is rarely fully paid or even possible to pay, the rehabilitation counselor, as representative of or consultant to the court, often deals with the issue of restitution. More importantly, future offender contacts with the victim are of concern.** In many cases the victim is a relative, neighbor, or co-worker of the offender, and some form of continued contact is unavoidable. In a few situations, the victim actively or passively precipitated the victimization process. Finally, the victim belongs to a class of persons likely to be further victimized by the offender. The rehabilitation counselor will do well to know and understand the victim as well as the victimization process unique to each offender.

Creation of the Adult Offender

What separates the offender from the nonoffender is, at times, a thin line. No single factor appears to cause a person to engage in criminal behavior. Research to date has not even turned up a convincing combination of causative factors that lead to crime or the criminal lifestyle. However, the body of information we do have enables us to assess, categorize, and intelligently interact with adult offenders to lower the risk of continued criminal behaviors, aid them in succeeding in rehabilitation programs, assign limited resources to offenders most likely to benefit from rehabilitation, and raise the potential for success in their lives.

Theories of Criminology—Basic Concepts

Despite the many often-competing theories about the cause of criminality, only some are of direct use to the rehabilitation counselor. The theories presented cover areas that might aid the counselor in choosing the best approach with a specific offender. It is limiting to use only one approach for an offender without clearly identifying what events and factors led to his or her present situation. **A blending of theories may best suit overall purposes of offender rehabilitation.**

Differential association of criminality, as described by Sutherland,[1] asserts that criminal behavior is learned in close association with others who commit crimes. Cultural conflict between classes, ethnicity, and race determine these associations, and individual differences affect differential association. Thus the people with whom the offender associates have a heavy influence on their criminal behavior. Obviously, offenders are forced to associate with other offenders through the CJS. Those who have lived in high crime areas and have other family members who are offenders are more at risk for continued criminal behavior. An offender's choice of friends and association with relatives should be carefully monitored and discussed.

Social control theory, as defined by Hirschi,[3] concerns conventional social control groups, such as family, nonoffender peers, and school. These groups, according to theory, fail to bond or bind to offenders. The more a person is attached and committed to a pro-social person or institution, the less time that person has to commit criminal acts. One must also remain involved in pro-social activities to accept the moral validity of societal norms.

Criminal behavior can sometimes be explained in terms of physical states and personality development. Quay[3] described the person with a psychopathic personality as highly impulsive, unable to learn from punishment, and unable to delay gratification. The term psychopathic personality is similar to the DSM-III-R diagnosis of antisocial personality disorder.[4] Psychopaths are always trying to create excitement without regard for consequences and show an inability to tolerate routine or boredom: it seems their only motivation is to achieve quick thrills. As children, the psychopaths were hyperactive, were aggressive, and constantly exposed themselves to danger, and their parents used a high level of punishment to control them. As they were severely punished, they became even more resistant to change. Then their parents avoided them, withdrawing love and affection. Rage in young psychopaths develops as a result of this battle between parents and children. As adults, psychopaths who were undersocialized by parents and community are unable to control inner rage and aggressive tendencies.

Stages of Criminal Development

There appears to be distinct stages in criminal lifestyle behavior. Walters[5] describes four: pre-criminal, early criminal, advanced criminal, and criminal burnout/maturity. In the *pre-criminal* stage, ages 10–18, thrill seeking is the primary motive for deviant behavior. Most offenses are minor, and most pre-criminal offenders cease such activity upon reaching adulthood. Those who continue to the next stage, *early criminal*, are between ages 18 and the 20s and

are more motivated by greed, laziness, and the need for drugs. Fewer, but more serious, crimes are committed. The following stage, ***advanced criminal,*** persists until the offender reaches his or her early 40s and is characterized by a driven quality to the criminal acts. The crime appears out of the control of the offender, possibly leading to the offender's death or incarceration. The last stage, ***criminal burnout/maturity,*** starts in the mid-40s. Because of loss of strength and stamina, offenders either quit crime altogether or revert to less physically demanding crimes, such as gambling.

With few exceptions, adult offenders are the product of a long line of failed interventions by family, school, social service agencies, and the CJS. The interventions were too little too late, and they lacked the in-depth understanding of the offenders. Therefore, they never secured the cooperation of the offenders. Starting at a young age, offenders work at avoiding both detection of destructive behavior and engagement in correcting that behavior. Thus, all interventions are bound to fail. Habits of avoidance and resistance are present in most repeat offenders. The rehabilitation counselor's approach is best served by recognizing that these ingrained reactions are nearly always present and must be dealt with early in the counseling relationship to limit sabotage by the adult offender.

The Criminal Justice System

The entire CJS is geared toward processing individuals accused of crime and managing those who are convicted. Anyone working with an adult offender would be wise to stay informed of the offender's status in the system. Often the offender is overly optimistic about his or her case or simply confused about the process. Denial of the reality of pending criminal charges is routinely experienced by an offender at any of the stages of prosecution. Treatment planning will obviously be misdirected if the counselor is unaware of an offender's future incarceration. If a rehabilitation counselor wishes to advocate for an offender in the CJS, he or she must know the

key points at which intervention is likely to be successful. Finally, **movement through the CJS will create crisis points** that, if anticipated through adequate discussion and planning, could be much less stressful for the offender.

ARREST:

Contact with the CJS nearly always begins with an arrest by the police. Arrested persons are either released and later summoned to court or are taken to jail, where they remain until released on bond or the case is disposed of. Because of the constitutional right to a speedy trial and the need to release pretrial inmates as soon as possible, **the accused are brought before a judge within 48 hours in most jurisdictions. At this appearance, bond is set and attorneys are appointed**—either identified by offenders or appointed by the court. Regardless of ability to pay, each accused has the right to an attorney.

BOND:

A very high percentage of individuals accused of nonassaultive crimes are released on bond. In some communities, determining release requirements is accomplished by the use of pretrial release investigators, who gather information on present community involvement, prior arrests, and past cooperativeness with court proceedings. Once released, the accused is required to periodically report to a pretrial release supervisor until court proceedings are completed.

DECISION TO PROSECUTE:

The prosecuting attorney's office then decides, based on police reports and other knowledge of the accused, whether to pursue criminal charges. A preliminary hearing is held in the lower court so that the judge may determine if there is sufficient evidence to bind (send) the case to the grand jury. There, the prosecutors present their charges and evidence, and the defense attorneys cross-examine witnesses for the first time if they so choose.

If the criminal act is determined to be a misdemeanor (an offense that carries a local jail sentence), the lower court disposes of the case. **If lower court judges determine that the offense is a felony (requiring a prison sentence), then evidence is bound over to a grand jury, which decides whether to indict the accused.** The prosecutors also have the option of taking the case, on their own, before the grand jury to seek an indictment.

In the grand jury hearings, evidence of criminal behavior is presented by prosecutors. **They need not prove that the accused committed the crime—only that a crime was committed, and evidence warrants further prosecution of the case. Nearly all charges brought before a grand jury by prosecutors result in an indictment, which means prosecutors have great discretionary power in pursuing charges.** The case can then be presented before the felony court. The accused is brought before the court, where the judge again sets bail and again ensures that the accused is properly represented by attorneys. The accused then enters a plea, virtually always "not guilty," and a trial date is set.

THE TRIAL:

The trial often does not take place: 95% of cases are resolved after the prosecutors and defense attorneys engage in a plea bargain. Of course, this stage has been anticipated by both sides. Prosecutors, with the help of the grand jury, attempt to level the most serious charges against the accused, and the defense attorneys have already collected as much proof as possible to discredit the state's case. Although the horse trading is started with each side hoping to have the greatest advantage in the negotiations, the process should be considered cooperative, not adversarial. Judges rarely intervene in the plea bargaining process except to ensure a timely and politically sound resolution of cases. They may even guarantee a specific sentence as part of a package deal offered by the prosecutor to the accused.

Much of the negotiations take place without the accused present, suggesting

an atmosphere of secret deals made by unscrupulous and cynical negotiators. This part of the legal process is probably the most suspect for both the victim and the offender population. **Victims are rarely informed about negotiations**, and offenders, at times accurately, feel they are railroaded into forgoing a trial and pleading guilty.

PRESENTENCE INVESTIGATION:

After an offender pleads guilty or is found guilty, he or she is referred to the probation department for a presentence investigation, which is to be completed within a specified time period. Usually, presentence investigators are probation officers who collect and compile data on the offenses and the offender's past and present status for the judge to use in sentencing.

Information on the offense includes police reports, the offender's version of the offense, and the victim's statements, which include losses incurred and the relation of the offender to the victim. Information on the offender includes prior arrest record; other pending criminal charges; family, school, and vocational history; as well as present conditions. The probation officer is usually required to make face-to-face contacts with at least the offender and the victim. However, other interested parties such as treatment staff, family members, and employers often come forward and present information to the probation officer for inclusion in the report.

Much of this information is gathered and compiled to aid judges in determining the offender's punishment, restitution to the victim, and chance of the offender remaining crime free in the community with the help of supervision and treatment. The report is also used by prison staff, parole officers and boards, and probation officers to determine supervision needs and treatment indications after the offender has been sentenced. The information in the report can include hearsay, opinion, and conclusion from other persons. Defense attorneys, prosecuting attorneys, and arresting police officers can and often do meet with the probation officer to discuss the presentence report. Varying greatly among jurisdictions and even

among individual judges, courts may ask for recommendations from probation officers. Agreement between probation department recommendations and actual sentences imposed by the courts is quite high. That may be attributed to the fact that probation officers significantly affect judges' sentencing or that judges and probation officers think alike in sentencing decisions. In any event, advocacy with the probation officer during the presentence stage would be valuable if there is concern that the judge will impose severe sentences without benefit of knowing positive aspects of the offender.

SENTENCING:

After the presentence reports are completed and sent to the judges, the offender is brought before the judge for sentencing. **Except for convictions that impose mandatory sentences, judges exercise wide discretion.** General guidelines, either self imposed or implied by past sentencing practices of other judges, influence the final sentence. Above all, the sentencing process, like all other court proceedings, is intended to assure a timely and orderly disposition of cases and continued effective working relationships among police, prosecutors, defense attorneys, and offenders.

With the incredible overcrowding at most penal institutions, the object of sentencing is, if at all possible, to prevent or reduce incarceration time. For a felony conviction, a judge can impose a prison sentence, with the offender only being released by the parole board usually to a period of parole supervision and a transition period with or without halfway-house residency. After prison incarceration, the judge can also release the offender on shock probation, which involves a short stay at the prison (30 to 90 days) and a release to probation supervision. The judge can also sentence the offender to a period of probation and local (jail) incarceration or work release incarceration, if available. Other specific treatments, constriction of freedom, or victim restitution can also be mandated.

Incarceration

Understanding the culture and effects of imprisonment is important because nearly all offenders undergo incarceration. Most are locally incarcerated for at least short periods of time, and a fair number are sentenced to reformatories or prison. The effects of the prison culture are felt by the offenders long after they leave prison. Prison enculturates the inmates into a life of restriction, deprivation, violence, abuse, and intense rage. Dependency can result from the overly controlled life. Inmates also develop working relationships ("contacts") with other inmates and learn the many skills associated with criminal activity. There they accept violence as a tool to attain status and to take from weaker inmates. Even if offenders are never incarcerated, they are exposed to the myths and realities of prison by other offenders, who brag about their incarceration, or corrections personnel, who often use the suspended prison sentence as a threat and provide offenders with lurid details of their last visit to prison.

MISTRUST:

Mistrusting everyone is a way to survive in the institution. The inmate must be part of a group, which may define itself in terms of whom it hates (another racial group) and from whom its activities are hidden (guards). The first step in working with inmates is to gain their trust in your competence and integrity. Often offenders approach their counselors as people to manipulate and as a source of benefits, because the counselor is identified with the rest of the authority figures. Important to the counseling process is helping offenders eliminate stereotypical reactions and see the counselor for who he or she is. Their fear of being victimized is very real.

VICTIMIZATION:

Victimization comes in many forms in prison. **Physical forms of victimization include assault, homicide, and rape.** The psychological form follows the physical. **Threats and intimidation** are used to take from the weaker inmates and create a social structure in which lower status members have very low self-esteem. The **economic form of victimization** reflects the crimes of society in general, including fraud, theft, and protection rackets.[6] **When counseling is available in prisons (often it is not), it has many limitations.** To begin with, **counseling settings in prison are rarely conducive to counseling.** A locked, barren room devoid of comfortable chairs or open windows is more common than a typical outpatient counseling office. **Counselors are unlikely to have sufficient time** to engage in long-term or insight-oriented counseling. Counselor qualifications and on-going training are limited at best. Prison resources are so few that treatment placement assessment and on-going counseling become futile processes for most inmates.[7]

Counselors are also expected to perform other prison functions, which take up time and compromise the counseling relationship with offenders. They can include the need for prison counselors to tell prison authorities about what they have learned in a counseling session in order to avoid inmate abuse or riots. With the above in mind, few offenders receive a positive impression about what counseling could be for them.

Probation and Parole

Probation and parole play a pivotal role in the management of the offender in the community. Without these two forms of supervision, the court system would be unable to dispose of the numerous criminal convictions, and the prison system would be unable to reintegrate the inmate into the community. However, the system is greatly overburdened, and, at present, is undergoing harsh criticism and self-evaluation. **One of the main difficulties inherent in both systems is the expectation that probation and parole officers are to be both counselors and law enforcers.[8]**

Probation and parole officers are directed by the courts and parole boards to monitor their offenders and report to the proper authorities any deviant behavior, including criminal acts, behavior likely to lead to criminal acts, or noncompliance with general or special rules of probation or parole.

Although the activities of probation officer and parole officer may overlap, a few important distinctions can be made between the two roles in the CJS. Probation officers are officers of the court who supervise offenders and ensure that the court has access to the offender for a specific length of time, as determined by the court. The offender put on probation need not have served any jail time. Therefore, probation is usually given for less serious crimes. Parole officers are officers of the state who supervise offenders after some period of imprisonment; therefore, parolees are more likely to have a greater number of convictions, to be less ammenable to treatment, and to have committed a violent offense. In addition, the parole officer is involved in the offender's release from prison and plays a crucial part in helping the offender reintegrate into the community. Generally, the parole officer, more so than the probation officer, emphasizes enforcement of supervision rules and protection of community.

In either case, the officers have **limited arrest powers over their supervised offenders,** and both groups of professionals by law have **the option to carry weapons while on duty.** However, **many departments have rules that forbid the carrying of weapons.** In some areas, probation and parole officers are expected to aggressively seek out, arrest, and transport to jail or prison an errant offender.

On the other hand, both parole and probation officers are directed to identify the treatment needs of the parolee or probationer and to help with service delivery. This process demands that they **create ongoing supportive counseling relationships** with offenders in order to maximize cooperation. In the counseling relationship, the offenders must confide their fears and deviant tendencies in order to change them. The officers must get close to the offenders in order to truly know and support them.

These two dramatically different roles can lead to numerous conflicts between officers and offenders and difficulty in relating to community service providers. To begin with, service agencies often are not equipped to deal with the many needs of offenders, whereas others have negative stereotypes of what offenders are and do. Still others have had bad experiences with offenders who are disruptive to their agency, noncooperative in treatment, and abusive to staff and fellow clients. In the opposite vein, some service agencies may perceive parole and probation officers as nonresponsive, intrusive, or overly punitive with their clients. To make matters worse, **offenders are masters in avoiding treatment obligations** by misrepresenting their reason for being referred to a particular agency or by gaining the sympathy and protection of agency staff. **It is imperative, although not always possible, for corrections and agency staff to communicate clearly the reason for referral and the ongoing actions and progress of all referred offenders.**

Determining Offender Risk

From the time the offender is arrested, correctional personnel need to determine the risk of offender noncompliance with the CJS and the risk that the offender may commit new offenses. Offender noncompliance can include failure to appear at scheduled court, probation, or parole meetings. It can also involve failure to complete treatment conditions, obtain or retain employment, or to be generally uncooperative. The risk of offenders absconding is of particular concern: when managing offenders or obtaining restitution becomes impossible, criminal behaviors often soon follow. **There is *always* a risk that a convicted offender will commit new offenses, because prior criminal convictions are the best predictors of future criminal behavior.**

Pretrial release has recently undergone much scrutiny because of overcrowded jails and overwhelmed courts. Generally, an assessment is made by court staff on the accused as to seriousness of the offense, prior criminal record, history of compliance

with court appearances, and stability of living situation, including employment, residence, and family. This assessment is presented to the judge, who uses the information in the preliminary hearing to determine risk when setting bail.

Objective risk assessment guidelines, used by sentencing judges, have been attempted without much success.[9] It appears that the plea bargaining process and the relationship between prosecutors—who initiated their own, personal risk assessment in deciding to proceed with prosecution—and judges preempt the use of objective guidelines on a voluntary basis.

Many probation and parole systems have implemented risk classification. The results of the assessments may result in placing inmates after release in halfway houses rather than home. **Risk assessment also is used to determine the number of minimum contacts that probation and parole officers are to make with offenders each month.**

Drugs and Alcohol Abuse

Drugs and alcohol abuse weaves its way into the fabric of the offender's life from an early age. Many offenders come from homes where parents abused alcohol and drugs. Early abuse leads to failure in school, inability to mature emotionally, and poor judgment—all precursors to criminal activity. Drug use is associated with crimes against property and persons. Obtaining money for drugs is likely to be done illegally, because of the cost of even occasional use. Thus, young offenders steal from parents, neighbors, and stores. Stealing can progress to burglary and robbery as the drug abuse progresses to addiction.

Counselors are cautioned against concluding that abstinence from drugs and alcohol means elimination of criminal behavior. In fact, sobriety may promote

an ***increase in criminal activity.*** **The offender becomes more capable of criminal acts because drugs are no longer clouding cognitive processes and more energy may be available to expend on crime. Furthermore, drugs may have inhibited aberrant sexual drives or rage, which are now free to be experienced and expressed.**

Because of the pervasive use of the defense mechanism of ***denial*** by drug and alcohol abusers and the care that most offenders take to avoid detection of their abuse, **it is never reasonable to assume an offender is drug free. Referral for assessment and treatment for possible substance abuse should be done if there are any suspicions about an offender's behavior.** All probation and parole staff should **familiarize themselves with signs of addiction, overdose, and inappropriate withdrawal from substances.** Staff should be taught appropriate actions and referral to medical facilities in the event of drug-related, life-threatening situations with offenders.

The Victim

Working with victims of crime is common for counselors who deal with offenders. Most victims who are seen by counselors in the CJS have already passed the crisis stage of being victimized. Probation and parole officers routinely contact victims after the offender is convicted, **usually several months after the offense is committed.** When speaking to these individuals, the **counselors should be familiar with the stages of grief and determine if the victims are within normal guidelines.[10] Counselors should also be sensitive to signs of post-traumatic stress disorder, particularly with victims of rape, assault, and kidnapping.** When discussing the traumatic event with victims, they should be aware that **very high levels of anxiety may result from reviewing what has happened.**

At times, the victim knows about the offender's treatment or correctional status and calls the counselor before contact is made with the police. **He or she may want**

to discuss the consequences of filing a police report or a way to get the offender to stop victimizing without having to involve the police. In these situations, the counselor may be dealing with a crisis resulting from the victimization. In the event that counselors are talking on the phone to victims who currently may be in danger, a series of questions should be asked: Are you hurt? Are you in danger now? Is the offender there now? Do you want me to call the police or rescue squad? Can you leave the situation?

Counseling Techniques

No one counseling approach can be applied to all offenders in the community. Instead, a variety of approaches, skills, and techniques that can be used with specific offender groups is important. Also important is the realization that within the offender population are identifiable groups that need special understanding and consideration.

COUNSELING FIRST-TIME OFFENDERS:

Many offenders enter the CJS for the first time as adults. Their lifestyle has been productive and law abiding, but a set of unusual circumstances has led to their commission of criminal acts. These people are usually followers and are unassertive. They may have married someone who is criminally oriented or have simply chosen a friend who led them into criminal activity. They may have existed in an environment that successfully contained their deviant behavior, such as married men whose wives provided needed sexual outlet that enabled them to contain secondary pedophilia (the compulsion to have sex with children when adult outlets are unavailable). When, after a long marriage, the wives are no longer available, these men may lose control of their deviant behaviors.

There are also those individuals who, faced with a financial or emotional

crisis—the loss of job or loved one—were led to a one-time criminal act to deal with the crisis. Unfortunately, they experience another crisis, or series of crises, as a result of being placed in the CJS. They endure financial stress because of attorney's fees, fines, and restitution. They suffer loss of self-esteem, overwhelming guilt, and loss of positive self-image, and they may lose their job or social standing in the community. They are subject to sliding into depression and other stress-induced psychological problems. Incarceration is very difficult, because they are easily victimized by fellow inmates and the system.

The counseling approach could be most effective as a combination of Carl Rogers's person-centered therapy, Carkhuff's systematic treatment training model, and assertiveness training (if the offender were seen as a follower).[11] Rogers's main goal for counseling was aiding the client in developing sufficient self-awareness and connection to feelings to be organismically directed: a person would be aware of and directed by his or her own feelings and insights. In order to achieve this, the counselor must be *empathic* (have the ability to understand, and communicate back to the client, what the client is experiencing from the client's frame of reference), *genuine* (consistent in what the counselor feels and says), and *non-judgmental*.[12,13]

Carkhuff extended Rogers's approach to include a phase of counseling in which counselors help clients become more active and self-directive in getting their lives back together.[14] These stages are listed below:

- **Facilitation**—emphasis on **building the relationship.** The counselor establishes himself or herself as genuine, caring, and non-judgmental.
- **Self-understanding**—emphasis on **client self-exploration.** The counselor makes use of empathic skills that help the client investigate and understand self, as well as become more directed by own values and feelings.
- **Action**—counselor is catalyst for client to **begin solving problems and carry out goal-directed problem-solving activities.**

The counseling emphasis is on getting offenders to understand their strengths and limitations, to take action to assure that they will not fall prey to other offenders in the CJS, and that they will be able to resolve crisis situations without reverting to criminal acts.

COUNSELING OFFENDERS WHO ARE DEVELOPING A CRIMINAL LIFESTYLE:

Reality therapy, developed by Glasser, has been used in a variety of correctional settings with much reported success.[15] It is based on the assumption that people have basic needs to love, be loved, and feel worthwhile to others. This can be achieved through a positive relationship with at least one other person. Being responsible to self and others, through obeying societal rules and fulfilling personal needs without hurting others is the only way to feel worthwhile.

In order for therapy to be successful, the therapist uses the following principles:

Personal involvement—the counselor communicates warmth and caring to the client. Personal experiences are shared by the counselor, who also lets the client know that the client can become happier, more effective, and more responsible.

Focus on present behavior—the counselor identifies behaviors as the cause of the client's problems. The counselor will point out the client's present behaviors that are causing problems and how to change those behaviors. The counselor rejects the irresponsible behavior—not the client as a person.

Focus on the present—the counselor will not let the client dwell on the past, except to identify how the client was able to develop character and solve problems presented in the past.

Value judgment—the client, not the counselor, must judge the client's behavior in the context of those around him or her.

Planning—the client is taught how to develop clear and attainable goals and plan to accomplish those goals.

Commitment—the client needs to commit to the counselor to improving self and working to obtain goals.

No excuses or punishment—if client fails to complete agreed-upon tasks, the counselor will neither ask for nor accept excuses for failure. The counselor will also not criticize or otherwise punish the client for failing in a task.

In applying these principles, the counselor would first develop a warm and caring friendship with the offender (not always an easy task). Present behaviors would then be discussed, rejecting the irresponsible behaviors and concentrating on the positive behaviors and successes. The offender would be taught to assess the value of the behavior, to ascertain realistic goals, and to develop plans to change behaviors with realistic goals, objectives, and action steps. The plans would be developed in a cooperative manner, and the offender would commit to accomplishing the goals in the plans. Progress would be reviewed in sessions, and the offender would be helped to deal with problems in achieving the goals without the counselor's criticism or the offender's excuses.

COUNSELING OFFENDERS WITH CRIMINAL LIFESTYLES:

Building from Ellis's rational-emotive therapy and from Yochelson and Samenow, Walters has identified eight cognitive patterns that are used by offenders in *maintaining* a criminal lifestyle.[16-18]

Mollification—offenders blame their criminal behavior on social injustices, circumstances leading to the offense, or the victims; it is an attempt to minimize the criminal behavior.

Cutoff—conscious actions on the part of offenders prevent the offenders from thinking about the consequences of their criminal actions. This is done to eliminate fears or thoughts that could make them hesitate or stop.

Entitlement—the feeling that the offenders have the right to others' property and that they are so special that the rules of society do not apply. With entitlement there is also the feeling that a basically non-essential want is really an essential need.

Power orientation—offenders feel they must have control over others, such as in armed robbery or rape. This becomes most apparent when they feel they are very vulnerable.

Sentimentality—a pattern in which the repeat offenders express tender feelings and normalcy even though they are deviant and destructive.

Superoptimism—the feeling that offenders can achieve anything, no matter how improbable.

Cognitive indolence—the pattern in which repeat offenders do not work hard at thinking things through, thus leading to behavior geared toward taking the easy way out of any situation at the cost of long-term problems.

Fragmentation—the pattern in which repeat offenders do not stay with a line of thought or a commitment to others. Goals are not reached because they are forgotten or carelessly replaced by other interests.

These cognitive patterns, found in career criminals, can be dealt with through a systematic assessment and intervention process. The first phase, ***assessment***, involves lifestyle analysis, developmental assessment, and cognitive profile. The presentence report contains information that aids in determining if the offender's lifestyle is marked by a history of irresponsibility, hedonism, and social rule breaking. If the lifestyle indicates a pattern of criminality, then developmental status is assessed

by reviewing age, type of crimes, and offender attitudes. The cognitive profile is obtained by listening for the eight primary cognitive characteristics listed above.

The second phase, *intervention*, begins by determining the offender's skill deficits—educational, vocational, impulse control, and interpersonal. The counselor operates as an educator to help reform the offender's thinking patterns and as a role model to demonstrate how to go about changing the faulty thinking that leads to criminal behavior. A counselor needs to be structured, firm, goal oriented, and organized in all relationships with an offender. These efforts can only be effective if the offender is ready to change and trust the counselor—resulting in offender and counselor becoming partners in rehabilitation.

The counselor works to enable an offender to feel disgust over the criminal acts and lifestyle, fully experiencing the hurt perpetrated on others and the way that the offender wasted his or her own life. This, hopefully, will inhibit the offender from experiencing the immediate gratification of a criminal act. Then, cognitive and behavior strategies will be taught to the offender to aid in avoiding situations that could lead to criminal acts.

Entitlement and *mollification* thinking is attacked by using rational-emotive therapy to identify and confront these irrational ideas. The irrational thought that maintains a feeling of entitlement is that the offender is privileged. The offender is also helped to differentiate between wants and needs. The *cutoff* technique is eliminated by training the offender to manage his or her stress level and control anger.

Self-control development, as well as combating the irrational thought that controlling others is a meaningful life goal, is helpful in overcoming the pervasive *need to control others*. *Sentimentality* is best confronted by forcing the offender to look at the pain he or she has inflicted on others and dispense with the idea of doing good deeds when committing crimes.

Superoptimism **is cognitively attacked, based on the destructiveness it carries for the offender.** It is also pointed out, through reviewing the offender's life problem situations, that it is a process the offender is sure to lose. ***Cognitive indolence*** **is lowered by helping the offender establish and reach personal goals.** This sets up good thinking habits. ***Fragmentation*** **is decreased by helping the offender get more control over angry thoughts, which disconnect thought processes.**

Helping an offender change life goals, expectations, and self-image into those of a consistently productive law-abiding person is not complete until the offender successfully enters mainstream society, which can then reinforce the noncriminal behaviors during the third phase, *follow-up*. Self-help groups, such as AA, NA, and CA, as well as treatment groups, can help in this process.

Counseling Populations With Special Needs

SPANISH-SPEAKING PERSONS:

Bondavalli and Bondavalli[19] have described many factors, including poverty, little formal schooling, and emotion, that make Spanish-speaking peoples a "population at risk" for being arrested and convicted of crimes. Yet, the sociocultural values and traditions often make the Spanish-speaking person a challenge to the culturally unaware counselor in corrections. If the offender cannot speak English or understands little English, it is important for the counselor to know Spanish or have an interpreter available. Counselors should also be aware of the reluctance of persons of Spanish heritage to discuss their family or problems with outsiders.

FEMALE OFFENDERS:

Ross and Fabiano[20] found that **female offenders present a different set of problems to probation officers. Issues of loneliness, dependency, and guilt are**

present. Female offenders are more manipulative and demand more time of the probation officer, and offender **pregnancy and motherhood** present unique problems to the counselor. Because females are so vastly underrepresented in the CJS, few programs have been developed to deal with those issues.

Vocational training and employment skills are seriously needed for the female offender. They must overcome the difficulties of being an offender as well as being female in the work environment. Training must help female offenders obtain work in an area that interests them and provides adequate pay, which often must meet the needs of an entire family.

Cognitive skills training is helpful for female offenders if tailored to their needs. **They appear to have deficiencies in the following abilities:** 1) Recognizing potential for problems in social interaction; 2) generating alternate solutions; 3) conceptualizing steps to obtain goals; 4) understanding how their behavior affects others' behavior; and 5) empathically understanding others.

Drug and alcohol abuse differs between male and female offenders. Female offenders are usually introduced to drug abuse by males, use drugs to deal with dependency and loss issues, and are better able to hide their abuse. Abuse programs must be evaluated to ensure that they are able to speak to problems specific to females.

OFFENDERS OF AFRICAN-AMERICAN DESCENT:

With one fourth of all young black males in prison, on parole, or on probation, it is obvious that they are vastly overrepresented in the CJS. However, **relatively few CJS components have black staff members who are in positions of power. This can lead black offenders to view the CJS as an institution in which whites dominate and purposefully degrade blacks.**[21] The CJS reflects the larger society in which young black males are increasingly displaced from work because of loss of heavy-

industry jobs; from schools because of a dysfunctional, poor-quality inner-city educational system; from stable neighborhoods because of destruction of inner-city homes; and from families because of stress and the breakdown of family values.

In enabling the displaced inner-city black offender to avoid further involvement in crime, numerous hurdles must be overcome. Educational and vocational skills must be improved, as well as the imparting of a value system that promotes optimism and inclusion rather than discouragement and rage. Finally, the very real issues of institutional and individual racism needs to be discussed so that the black offender is able to determine what can and what cannot be changed.

These special-needs groups have a parallel with offenders who have physically or mentally disabling conditions. Special training is needed to work with both sets of groups.[22]

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QUESTIONS BASED ON THIS LESSON

17. Which of the following statements is correct?

    A. All individuals who are arrested for a crime must appear before a grand jury for possible indictment

    B. Plea bargaining is rarely done, and when it is, both the offender and the victim are actively included in the process

    C. The risk of criminal behavior can actually increase when offenders who have been substance abusers become drug or alcohol free

    D. Probation and parole officers are given responsibility for the psychological and social rehabilitation of offenders without any requirement to monitor and report on deviant behavior

18. Which of the following is the major theme of Sutherland's concept of differential association of criminality?

    A. Conventional social control groups, such as family, nonoffender peers, and school fail to bond or bind offenders

    B. Criminal behavior results primarily from a psychopathic personality structure

    C. Abnormal biochemical findings are common among offenders

    D. Criminal behavior is learned through contact with others who commit crimes

19. In the so-called early criminal stage of criminal development:

A. The major motives appear to be greed, laziness, and the need for drugs

B. There is a driven quality to the criminal acts

C. Lacking stamina, offenders usually engage in less physically demanding crimes like gambling

D. Thrill seeking is the primary motive for deviant behavior

20. Which of the following cognitive patterns used by offenders to help maintain their criminal life style is said to be specifically attacked by techniques to enable them to gain greater control over angry thoughts?

A. Entitlement

B. Fragmentation

C. Mollification

D. Cognitive indolence

Directions in Rehabilitation Counseling

VOLUME 3 • LESSON 6

Co-Dependence: A New Diagnosis

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EDITOR'S NOTE

In this lesson, the authors explore the concept of co-dependence. The notion itself arises from innovative approaches to the treatment and rehabilitation of patients with substance abuse, including alcoholism. However, it has a long history among those dealing with neurotic interactions in marriages and other forms of pathologic interdependency, as in various "love" relationships.

Rather than seeing the families of addicted or abusive patients as perpetrators, they are viewed as suffering with their own desperate attempt to control their actually or seemingly unmanageable lives, using denial as a major defense maneuver. Whether the family members are so conditioned by their own childhood experiences or by living with exploitive, abusive lovers or spouses, or a combination of both, they tend to become deeply enmeshed in relationships from which they vainly hope to obtain approval and a sense of personal worth. Ironically, although it is the client who needs the family, the family members experience the interactions as though they need the patient to give them something that the patient is usually quite incapable of giving.

Five co-dependent roles are defined: the enabler, the family hero, the scapegoat, the lost child, and the mascot. Each is designed to cope with dysfunctionality. In assuming any one of these roles, the co-dependent individual becomes restricted and inflexible, minimizes his or her own feelings, tends to become depressed and may at times become suicidal, and runs a risk of becoming abusive or chemically dependent. A need to "be of help to the other" can reach truly pathological proportions. The choice of a career in a health profession can easily be motivated by such a need; when this is so, countertransference issues must be carefully attended to so as to prevent aggravating clients' dependencies.

Introduction

Two trends in contemporary psychotherapy have contributed to a growing interest in the diagnosis of "co-dependence." The first is the renewed emphasis on psychopathological diagnosis in general,[1-12] which has stressed biological contributions[13,14] and maintained a strong focus on affective and anxiety disorders.[15-19]

The second trend that has spurred interest in the diagnosis of co-dependence has been the drug abuse epidemic, which has created a huge industry that treated more than 600,000 Americans for substance use disorders in 1987.[20] Substance use disorders, affective disorders, and anxiety disorders are the three most prevalent classes of mental disorder in the United States. Most surprising to many therapists was the finding that 24% of American men and 4.5% of American women (16.4% for men and women combined) met DSM-III diagnostic criteria for substance use disorders during their lifetime, making substance abuse the most common lifetime diagnostic group in the nation.

Whereas substance abuse treatment in the early 1970s was predominantly publicly funded and directed toward heroin addiction and alcoholism, the 1980s saw the emergence of private inpatient treatment for what became widely known as chemical dependence. The major innovation of the private programs was the Minnesota Model, which used inpatient treatment not for detoxification but to overcome denial and to educate patients and their family members to the disease concept of chemical dependence.[21] Before discharging patients, the new chemical dependence programs routinely recruited them into the lifelong fellowship of 12-step programs, such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). Family members, having learned that chemical dependence was a family disease and that they needed to work for their own personal "recovery," were referred to mutual-aid programs for relatives of chemically dependent people.

This pattern of practice spread rapidly during the 1980s and became virtually universal by 1990, largely because of the dramatic results it produced when compared with earlier, more traditional medical and psychiatric approaches to treatment. Many of the therapists in the chemical dependence programs—including the professional staff of psychiatrists, nonpsychiatric physicians, psychologists, and counselors—were themselves "recovering" from personal chemical dependence and were members of 12-step programs.

One of the most powerful ideas underlying the disease concept of chemical dependence was that family members suffer from the disease in a way that was parallel to, and as serious as, the way addicted people suffer, and that family members needed help to meet their own needs, not simply to assist the chemically dependent family member. This view changed the earlier definitions of the family role in addiction: traditional family therapy saw the family of the addict as needing and perpetuating the pathological behavior of the addicted person. It viewed the illness of the addict as necessary to maintain the homeostasis of the family: the addict was the victim of the disordered family system.[22,23]

In the newer formulation of the disease of chemical dependence many of the family members living with addicts are not unconscious promoters of the pathological behavior but are ill in their own right with an identifiable disease. They, like the addict, suffer from denial as they attempt to cope with their inherently unmanageable lives. Their attempts to gain control of their lives—and the addict—are part of the problem, not part of the solution. These family members, for the sake of their own recovery, need to admit they are powerless over the addict and focus on their own lives, rather than living through the addict. For most family members of addicts, help to overcome their own part in the disease lies not from traditional psychological treatment approaches but rather but from the 12-step programs. It is important, in this view, for the family members to overcome their disease, even if they are no longer living with or relating to the chemically dependent person, since the family member's own disorder continues to have a powerful negative effect on his or her own life.

TABLE 1—Some Definitions of Co-Dependence

1. ...an exaggerated dependent pattern of learned behaviors, beliefs and feelings that make life painful. It is a dependence on people and things outside the self, along with neglect of the self to the point of having little self identity.

2. ...preoccupation and extreme dependence (emotionally, socially, and sometimes physically) on a person or object. Eventually, this dependence on another person becomes a pathological condition that affects the co-dependent in all other relationships. This may include...all persons who (1) are in a love or marriage relationship with an alcoholic; (2) have one or more alcoholic parents or grandparents; or (3) grew up in an emotionally repressive family.... It is a primary disease and a disease within every member of an alcoholic family.

3. ...ill health, maladaptive or problematic behavior that is associated with living with, working with or otherwise being close to a person with alcoholism (other chemical dependence or other chronic impairment). It affects not only individuals, but families, communities, businesses, and other institutions, and even whole societies.

4. ...an emotional, psychological, and behavioral pattern of coping that develops as a result of an individual's prolonged exposure to, and practice of, a set of oppressive rules—rules which prevent the open expression of feeling, as well as the direct discussion of personal and interpersonal problems.

5. ...a personality disorder based on: a need to control in the face of serious adverse consequences; neglecting one's own needs; boundary distortions around intimacy and separation; enmeshment with certain dysfunctional people; and other manifestations such as denial, constricted feelings, depression, and stress-related medical illness.

6. ...a stress-induced preoccupation with another's life, leading to maladaptive behavior.

7. ...a disease that has many forms and expressions and that grows out of a disease process that...I call the addictive process...the addictive process is an unhealthy and abnormal awareness and leads to a process of nonliving which is progressive....

Source: Whitfield CL. Co-dependence—Our most common addiction: some physical, mental, emotional and spiritual perspectives. Modified from a special 1989 issues on Co-Dependence in *Alcohol Treatment Q*, vol 6, 1988.

Definition of Co-Dependence

Co-dependence is a pattern of painful dependency upon compulsive behaviors and on approval from others in a search for safety, self-worth, and identity. Recovery is possible.

This definition was adopted at the First National Conference on Co-Dependency, which was held in Scottsdale, Arizona, in 1989. Whitfield wrote, "**Co-dependence is a disease of lost selfhood. I define it as any suffering and/or dysfunction that is associated with or results from focusing on the needs and behaviors of others.**"[24] It is a diagnosis that has grown out of the community of sufferers, and it appears to be moving from wide public use to formal diagnostic status.

Originally, the term co-dependence was used exclusively to describe the symptoms or behavior of people living with an alcoholic or an addict. As the term co-dependence gained acceptance, it has come to take on a wider meaning and is increasingly seen as one of many outcomes of living in a family dominated by substance abuse. However, many self-defined co-dependent people are members of dysfunctional families that have not suffered directly from substance abuse.[25]

Co-dependence can be seen as a personality trait or a personality disorder. Cermak was the first to fit this new diagnosis into the category of personality traits/disorders.[26] In the language of DSM-III-R:

Personality traits are enduring patterns of perceiving, relating to, and thinking about the environment and oneself, and are exhibited in a wide range of important social and personal contexts....

The diagnostic criteria for the Personality Disorders refer to behaviors or traits that are characteristic of the person's recent (past year) and long-term functioning since early adulthood. The constellation of behaviors or traits causes either significant impairment in social or occupational functioning or subjective distress.[3]

Many Americans have been educated about this diagnosis of co-dependence by their own participation in Al-Anon, Alateen, Children of Alcoholics (COA),

Co-Dependents Anonymous (CoDA), and other mutual-aid programs. Self-definition of co-dependence has resulted from reading the burgeoning popular literature on addiction and recovery, which has co-dependence as one of the principal topics;[27-30] from "family week," which takes place as part of a Minnesota Model 28-day residential treatment program for chemical dependence; and from co-dependence treatment programs that have been developed, often in close association with private addiction treatment programs, both outpatient and inpatient.

Professionals familiar with such developments in the treatment of CD have sought to bring the diagnosis of co-dependence into the psychotherapeutic mainstream.[26,31] Whether their efforts succeed or not, all health professionals must become familiar with the term "co-dependence," because it is now widely used and many clients have applied the diagnosis to themselves. At a minimum, practicing therapists should be able to "talk the talk" of co-dependence and use the concept to help those who are dealing with addiction in their families. **At a more ambitious level, the new focus on co-dependence as a formal psychiatric diagnosis of a personality disorder can help mental health professionals think more creatively about diagnosis, focusing more on the persistent and interactive contexts for psychopathology.** It means thinking about personality disorders and diagnoses beyond a biologically based snapshot, as most diagnoses now tend to do.

Arguments Against a Co-Dependence Diagnosis

Not everyone has been persuaded by the public support for the diagnosis of co-dependence. Stanton Peele, author of *Diseasing of America: Addiction Out of Control*, calls co-dependence "...a condition for which groups organized like AA are provided and about which best sellers are written."[32]

Phyllis A. Mullaney, an alcoholic services specialist, says co-dependence is a word that

> ...takes an entire category of people and labels them as damaged goods; strips families affected by alcoholism of their individuality; provides a false sense of self-esteem and worthwhileness that "codependents" wear like a fur coat, fearful of removing it because it is so warm and comfortable, and a self-fulfilling prophecy that sabotages focus on one's self by its very title.[33]

For still others, co-dependence is "the latest good excuse," or a generic term.[33]

Examples of Co-Dependence

The most classic example of co-dependence is the adaptational response of an individual with a behaviorally disordered family member, such as an abusive or chemically dependent spouse. In order to remain in such a relationship, the co-dependent person must undergo a powerful adaptational, restrictive response. During the co-dependent person's childhood, the patterns of behavior, thinking, and communication (or rather lack of communication) become deeply ingrained.

Because psychotherapy holds individuals responsible for their behavior, the patterns of co-dependence are often thought to be intrapersonal, becoming so after prolonged exposure to the toxic, dysfunctional setting. That may confirm the implications of the current diagnostic approaches, which locate disorders within the individual and not with an interpersonal framework.[34] However, like post-traumatic stress disorder (PTSD), the origins of co-dependence lie not only within the individual but also within the chronic stress of dysfunctional interpersonal relationships.

According to an often-quoted observation attributed to Black,[35] co-dependents "cannot trust, feel, or communicate." As a result, rigid and stereotyped roles are often adopted. Their dependencies on pathogenic individuals are great, and their options for individuality and individual development are constricted.

Roles of Co-Dependents

Co-dependents often take on one or more roles that have been identified as typical among rigid and enmeshed dysfunctional families and in groups as first described by Black,[35] Satir,[36] and Wegscheider.[37] The same roles exist in healthy families, possibly with the same frequency as they do in families dominated by addiction, but in dysfunctional families, the roles tend to be more rigid and result from family needs rather than the needs of the individual. Whether they occur in dysfunctional families or in healthier families, it is often helpful for all involved—including therapists and counselors—to understand those specific roles and to see the limitations on the individual's human potential such rigid adherence to those roles can cause.[25] The more common roles have been termed enabler, family hero, scapegoat, lost child, and mascot or baby.

ENABLER:

The role of "enabler" is often played by a spouse who is attached as an adult to an abusive and/or chemically dependent individual. The enabler attempts to be responsible for family function and the relationship by taking over the addicted person's responsibilities and functions, assuming that sharing and mutuality are impossible. Those roles are often learned in childhood and are continued in adult life by selection of partners who are similar to the parents they knew as children. The result is a diminution of a sense of self separate from the addict and a restriction on personal self-esteem, degrees of freedom, and independent action, particularly relative to the world outside the relationship.

FAMILY HERO:

The family hero, who may be an older child or sometimes a single child in a dysfunctional family, provides a sense of accomplishment and links the family to the

outside world. Family heroes often share with enablers the role of family organizer. They are often excellent performers outside the family because of the leadership role learned within the family. However, as a result of the sacrifices made to be co-dependent, they lose their sense of self as well as their abilities to trust, communicate, be in touch with their emotions, and control their relationships. Many are attracted to careers in health care.

SCAPEGOAT:

Family scapegoats have difficulties with their adaptation in the family and may seek recognition outside the family as a result of their loneliness. They often provide a focus for their family's energies because of their difficulties, thereby diverting attention from dysfunctional, addicted, or abusive family members. They, more so than most other co-dependents, identify more closely with the dysfunctional addict, yet they often seem more blameless in their own dysfunction.

LOST CHILD:

The lost child is often a lonely, withdrawn, depressed individual who adapts to the dysfunctional family system through isolation. The demands on the family are thus lessened, but such individuals feel rejected, are unable to relate in interpersonal systems, show poor performance in the outside world, and have a limited ability to trust.

MASCOT OR BABY:

The family mascot or baby survives by being stuck in the family system, by attracting attention, by being cute and/or funny, and by being a partner, often for life, of other dependent or co-dependent family members.

Impact of Co-Dependence Roles

The five common themes on the role of the co-dependent are not mutually exclusive, nor are they exhaustive of the maladaptive behavior patterns of co-dependent people. The roles are not fixed over time for any particular individual; instead, these patterns, like the diagnosis of co-dependence itself, are helpful to identify and overcome particular, easily recognizable patterns of maladaptive behavior. They each represent constrictions on the development of the individual's own identity and roles in the world.

The roles adopted during childhood in a dysfunctional family often continue as rigid characterological patterns, the personality disorder of co-dependence, if alternate ways of communicating, feeling, trusting, and relating are not found. **Roles are learned in order to survive as children or as adults in an environment from which escape seemed impossible.** Co-dependent people may be able to switch or share roles, but they are seldom able to move beyond them without help. Their symptoms can be progressive.

Co-dependents often find themselves being caretakers of other troubled individuals, have low self-worth, and tend to repress and minimize their own feelings. Communication difficulties, poor self boundaries, and deficient abilities to manage feelings and emotions are common. They may have physical, sexual, or psychological problems growing out of that pattern of living, such as being **chronically depressed and withdrawn.** Co-dependents may become **suicidal or aggressive** toward others, **may abuse their own children,** or may have recrudescence of symptoms of co-dependence as they raise their own children. Co-dependents are at **high risk for development of substance abuse or other addictions themselves.**

Diagnostic Criteria for Co-Dependence

Based the writings of Cermak, five elements must be present in the diagnosis of co-dependence. They are: 1) **an ongoing investment of one's self-esteem in the**

ability to influence and control feelings and behavior—both in oneself and in others—in the face of serious adverse consequences; 2) assumption of responsibility for meeting others' needs to the exclusion of acknowledging one's own needs; 3) anxiety and boundary distortions related to intimacy and separation; 4) enmeshment in relationships with personality-disordered, chemically dependent, and impulse-disordered individuals. The fifth element is the presence of at least three of the following: excessive reliance on denial; constriction of emotions, with an abnormal number of dramatic outbursts; depression; hypervigilance; compulsions; anxiety; substance abuse; recurrent victimization from physical or sexual abuse; stress-related medical illness; and remaining in a primary relationship with an active substance abuser for at least 2 years without seeking outside support.

Cermak[38] related co-dependence to the cluster of personality disorders characterized by dramatic, emotional, or erratic behavior, and by anxious or fearful behavior (clusters B and C), and to a lesser extent by the cluster of personality disorders characterized by odd or eccentric behaviors (cluster A). The core of the personality traits of co-dependence is a distorted relationship to willpower and a persistent sacrificing of personal identity in the hope of having intimacy with a pathological partner. Co-dependence has many characteristics that are similar to some familiar DSM-III-R personality disorders; however, co-dependence may be distinguished by its unique syndrome characteristics. Recently, Cermak has set co-dependence in a broader context of all that happens to adult children of alcoholics and distinguished between onset of co-dependence in childhood and in adulthood.[25,39]

Differential Diagnosis

The differential diagnosis for co-dependence covers a broad range of signs and symptoms. For example, co-dependence and dependent personality share many characteristics, but dependent personalities are generally more passive, self-effacing, and docile, whereas co-dependents are frequently (although often

unconsciously) active, manipulative, and willful in their relationships. Avoidant personalities are often socially withdrawn, a pattern sometimes seen in the "scapegoat" and "lost child" roles of co-dependence. However, most co-dependents are highly involved in many relationships and appear competent both within and outside the family.

A Dynamic View of Co-Dependence

Co-dependence has a complementary relationship to narcissism. Cermak[38] and Freud[40] related co-dependence to the narcissism of the addicted person, citing the myth of Narcissus, who would not return the love shown him, and Echo, who was condemned to speak only what was said to her. The book, *Alcoholics Anonymous* (the "Big Book"), identifies narcissism as the fundamental problem of the alcoholic with these words: "Selfishness, self-centeredness, that we think is the heart of our problem."[41] Heinz Kohut implicitly supported this common view of members of Alcoholics Anonymous when he focused on the narcissism at the center of the psychopathology of addiction.[41]

The narcissism of addiction exists as a complementary part of a whole family system, with the less visible part being co-dependence. Co-dependents submerge their sense of self in a quest for survival in a seemingly inescapable relationship with the addicted person. They come to believe their happiness depends on grandiose—but apparently self-effacing—efforts to remake the addict. In that complementary, dyadic relationship lies the heart of the disease. For both the addict and the co-dependent, recovery lies in overcoming it. Paradoxically, only by becoming more independent of each other can the co-dependent and the addict find mature mutuality and love for self and for each other.

The 12-Step Programs

In discussing modern mental health care, psychiatrists such as Sabshin point proudly to the contemporary focus on biological psychiatry and to the use of potent psychotropic medicines.[48] What has been largely overlooked in contemporary psychiatry and medicine in general is the other powerful revolution going on in the mental health fields: the 12-step movement. Aesculapius, the Greek god of health care, had two daughters: Panacea, the goddess of medicine, and Hygea, the goddess of healthy living. Modern medicine has rediscovered Panacea. If health care is to thrive and fulfill its mission of helping people in pain, then it will have to balance reliance on Panacea with reliance on Hygea. The 12-step programs, and the diagnosis of co-dependence, offer an opportunity to help achieve that goal.[49]

Many mental health professionals remain insufficiently familiar with the 12-step programs, including those dealing with family members affected by someone else's drinking and/or drug use. Khantzian and Mack,[43-44] explored the relationships of these programs to contemporary psychodynamic theory. Referring specifically to Alcoholics Anonymous, but with language clearly relevant to all 12-step programs, they concluded that the success of such programs rests in the sharing of problems related to self-regulation.

Two interrelated dimensions of the character defects—those that the co-dependent person brought to the relationship with the drinking and/or drug-using person, and those that developed in reaction to that drinking and drug use—are dealt with in the 12-step programs that are more focused on co-dependence. Al-Anon, Children of Alcoholics, and Co-Dependents Anonymous offer a unique, workable framework for understanding and overcoming those character defects. Their primary message is to surrender the goal of changing the drinking and/or drug-using person and to focus instead on developing a separate, effective sense of self. Such techniques help the co-dependent person toward effective self-regulation and self-governance.[43-44]

Treatment Perspective

Not only must therapists and other health professionals be able to make a positive diagnosis of addiction, they must also be able to diagnose the pathological complementary relationships that surround the addict. Therapists must be able to identify the condition of co-dependence, understand it, and be capable of discussing the syndrome with their clients and their families. Comprehensive treatment of addiction involves helping co-dependents overcome denial of their central role and take the steps necessary to change their own patterns of behavior. Although traditional individual and family psychotherapy may be helpful in that process, the specific treatment for co-dependence for most poeple is to join a 12-step program and "work the program." Mutual aid groups for families are usually indicated, often with attendance at meetings at least twice a week for many years. Clients can also be referred to the ever-growing self-help literature on co-dependence, such as the writing of Wegscheider-Cruse and Cruse.[45] Of course, addicts, who are usually also co-dependent, must never substitute these co-dependence programs for their primary program. Addicts may profitably use one of these programs later with their primary program to promote their sobriety.

Cermak[39] has distinguished between primary, or child-onset, co-dependence and secondary, or adult-onset, co-dependence. The former often requires intensive and prolonged treatment, including both mutual-aid groups and psychotherapy; the latter often responds to less intensive, prolonged interventions of education, psychotherapy, and mutual aid.

The primary form of co-dependence has a pervasive impact on the process of identity formation. This, in turn, leads to the development of rigid patterns of maladaptive behavior and sparse development of more healthy components of identity. In secondary co-dependence, the affected person responds to the dysfunction of others by heightening latent traits of co-dependence to the level of a personality disorder.[39]

Both mutual aid and psychotherapy can help co-dependents recognize maladaptive character traits and develop new, healthier, and more adaptive behavior patterns. That process of change is facilitated by altering the family dynamics, with a core treatment goal of helping the co-dependent person "detach with love" from the pathological bond with the addict and the addict's narcissism.

Implications for Psychotherapy

There are important implications for psychotherapists and health professionals in understanding and treating co-dependence.[46,47] Recognition of the diagnosis of co-dependence forces the treatment community to acknowledge the impact of the 12-step movement in contemporary America—specifically its impact on understanding and overcoming addiction.[46,47] That acknowledgement will benefit the profession, because **the insights and techniques developed in that mutual-aid movement not only are powerful but also have wide applicability.** Therapists are often confronted with behaviors in their clients that are both pathological and fixed. Having the 12-step movement as an ally in overcoming such behavioral patterns is an important addition to the therapeutic armamentarium.

Therapists and other health professionals owe it to themselves and to their clients to attend AA, NA, Al-Anon, Alateen, or COA meetings so that they understand this 12-step movement in a direct, personal way. They must be able to refer their clients to these mutual aid programs. The best way to do that is not by giving simple advice ("go to the meetings") but to **refer the client to a specific active and experienced member of a 12-step fellowship so the introduction can be personal. That is especially important for co-dependent clients, because their pride and their usually hidden sense of vulnerability make turning to anyone for help particularly difficult.**

Most co-dependents, like most addicts, have an underlying fear that makes the acceptance of a referral to a 12-step program very difficult. Some

co-dependents find it easier to accept referral to a professionally run treatment program than to accept direct referral to a 12-step program. Many contemporary chemical dependence treatment programs offer inpatient and outpatient programs specifically for co-dependent people. An organized co-dependence treatment program seems to many co-dependents to be a safer way to begin to deal with their difficult life situations. After they leave such treatment it is easier for them to go to 12-step meetings. This same pattern—professional treatment followed by 12-step work—is common in the treatment of addicts and alcoholics.

Denial is at the heart of both addiction and co-dependence, so the initial referral is both crucial and difficult. Referral to 12-step programs by the therapist or counselor must be done wisely, compassionately, and with determination. Additional information can be obtained from Al-Anon, Alateen, Co-Dependents Anonymous, Children of Alcoholics, and the Hazelden Clinic (see Table 2).

TABLE 2
Sources for Information on Co-Dependence

Adult Children of Alcoholics (ACOA)
Central Service Board
Box 35623
Los Angeles, CA 90035

Children of Alcoholics Foundation, Inc.
PO Box 4185
Grand Central Station
New York, NY 10163-4185

Al-Anon Family Group Headquarters, Inc.
PO Box 862
Midtown Station
New York, NY 10018-0862

Co-Dependents Anonymous (CoDA)
Box 33577
Phoenix, AZ 85067

Hazelden Educational Materials
Pleasant Valley Road
Box 176
Center City, MN 55012-0176

Conclusions

The new diagnosis of co-dependence offers important opportunities for therapists. Co-dependence is a unique personality disorder characterized by a pathological attachment for an addict (***or other dysfunctional individual***) with a search for safety, self-worth, and identity through the control of that individual. It produces constriction in the emotional life and identity of the co-dependent person, making him or her a complement to, and an echo of, the addict.

The recognition of co-dependence is important for understanding and overcoming the dysfunctional family patterns at the root of chronic addiction. The specific treatment for the personality disorder of co-dependence is regular participation in 12-step programs. Specific inpatient and outpatient treatment programs for co-dependence may also be helpful for co-dependent people, just as it is for addicts, in overcoming their fear and resistance to entering treatment. Both individual and family psychotherapy can be useful, and recovery is possible for both the addict and the co-dependent, but they both have lifelong disorders.

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QUESTIONS BASED ON THIS LESSON

21. Which of the following statements is correct?

    A. Patterns of co-dependence are exclusively interpersonal, and removal of the abusive or chemically dependent other cures the problem entirely

    B. The proclivity to be a co-dependent is entirely determined by genetic influences

    C. Co-dependence is often regarded as intrapsychic, but becoming so after prolonged exposure to a toxic, dysfunctional interpersonal setting

    D. None of the above

22. The "Minnesota Model" of drug use rehabilitation:

    A. Directed efforts primarily at detoxification

    B. Emphasized overcoming denial and educating patients and family members to the disease concept of chemical dependence

    C. Rejected the 12-step programs in favor of intensive individual psychotherapy

    D. Excluded family members from participation in rehabilitation programs, thereby diminishing their detrimental influences

23. Which of the following statements is correct?

    A. "Enabler" is a term reserved for those who help addictive or abusive persons overcome their problems

    B. Family "heroes"—who take on leadership qualities in work and academics—are invulnerable to being pulled into being co-dependents

    C. The "scapegoat," who provides a focus of family energies and concerns, can attract attention away from dysfunctional parents or other addicted or abusive family members

    D. The "mascot" engages in a co-dependent role with abusive or addictive family members by persistent, attention-getting antisocial behavior

24. The contemporary view of the family's involvement in substance use disorders stresses that:

A. The family needs and perpetuates the patient's pathological addictive behavior

B. The addict's behavior is essential to maintain the homeostasis of the family group

C. The addict is a victim of a disordered family

D. Family members are ill in their own right, suffering from denial as an effort to cope with inherently unmanageable lives

Directions in Rehabilitation Counseling

VOLUME 3 • LESSON 7

Evaluating the Deaf Client

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EDITOR'S NOTE

This lesson poignantly emphasizes how a serious sensory deficit, such as deafness, can confuse the clinical picture of psychopathologic disorder and provide very special conditions to diagnostic and therapeutic procedures. When deafness is present in infancy and before language skills develop, the effect on object relations, identity formation, and other developmental tasks can be profound. Misdiagnoses in the deaf are common; for instance, because the nature of manual communication is concrete and syntax specific, the client may seem to be manifesting a schizophrenia-like looseness of associations; on the MMPI, nonschizophrenic deaf clients may score high on the schizophrenia scale as a result of their basic isolation. Personality traits, such as bluntness, emotionality, or self-centeredness which arise largely from the conditions of deafness and the environment in which the deaf person grows up and lives may often be confused with characterologic disorders.

Three types of deafness are defined. The first, prelingual, can have a profoundly negative effect on behavior. Deafness that begins later on, resulting, from such diseases as rubella or meningitis, can be seriously disabling. Of the 14 million people in the United States known to be hard of hearing, about 200,000 are prelingually deaf and 1.8 million are severely impaired postlingually. Most elderly individuals fall into the "hard of hearing" type, a condition that often can be ameliorated with hearing aids.

In my own practice, I have only occasionally encountered the "hard of hearing." In my own family, however, there is one instance of unilateral deafness that began following a childhood infectious disease. Because of a several year delay in recognizing the problem—concealed by the child's resourcefulness and insufficient alertness on the part of family, pediatrician, and school teachers alike—the child was considered of very average intelligence. In fact, his intelligence was well above average, as later accomplishments proved. With the correction of the impairment (effective seating in the school room, unilateral hearing aid, etc.) performance improved, but full correction of reading and writing deficits took several years to complete.

Introduction

For therapists and counselors unfamiliar with deafness, the evaluation of deaf clients can prove to be difficult and may result in misdiagnosis. Independent investigations by Rainer and Altshuler[1] and by Trybus and Edelstein[2] found **communication difficulties and misdiagnosis accounted for the larger-than-expected population of deaf inpatients in public psychiatric institutions and for numerous diagnoses of schizophrenia, affective disorders, and mental retardation.** Rainer and Altshuler[3] often found the **diagnoses made by mental health professionals trained to work with deaf individuals to differ from those made by hospital psychiatric staff without such training.**

Difficulties in evaluating deaf patients can be attributed to various factors: 1) Counselors and other mental health professionals receive **little formal training** in the diagnosis and treatment of deaf clients;[4] 2) **a deaf client's limited communication skills force the therapist to rely too heavily on observation;**[5] 3) interpreters may inhibit therapeutic interaction;[6] 4) some deaf individuals suffer from **concomitant organic mental deficits that need to be distinguished from functional disorders;**[7] and 5) the results of **psychological testing of the deaf may easily be misinterpreted.**[8] In addition, the literature on deafness can be confusing because it ranges from suggestions that deaf individuals are mentally deficient or have personality problems to claims that they are as well adjusted as the general population.[8] Little has been written on neuroses and character disorders in deaf individuals.

Prelingual deafness, a hearing loss that is present at birth or occurs prior to language development, leads to severe linguistic and literary problems in those so afflicted. The social and behavioral difficulties of prelingually deaf individuals have caused them to be viewed as being of limited intelligence and subjects of humor and ridicule.[9] Pejorative terms such as "deaf and dumb" and "deaf mute" suggest decreased intellect or nonworking vocal cords. **The preferred reference term, "hearing**

impaired," subsumes the varying categories of hearing loss. "Deafened" individuals, those who have lost hearing in later life, are distinguished from "deaf" individuals who have lost hearing prior to their language development (prelingual) and commonly use manual communication. The term "hard of hearing" generally refers to an individual with enough residual hearing to be able to communicate with the assistance of a hearing aid.

In the United States, 14 million individuals are hearing impaired. Of those, 200,000 are impaired prelingually, and 1.8 million are deafened or severely hearing impaired postlingually.[8] Though the latter most commonly suffer from depression, isolation, and insecurity, they are spared the developmental and early social compromises affecting the prelingually deaf.[10] In both groups, the severity of limitations and degree of adjustment needed are dictated by such variables as the etiology of hearing loss, age of onset, degree of hearing impairment, educational environment, and reaction of others to the impairment.[11] Attention to those variables and understanding of the influences of prelingual deafness on development, personality, communication, cognition, and socialization are critical for proper assessment of deaf clients.

Development and Personality

Hearing and speech are important for the development of object relations, in identity formation, and in ego control of affect and drives. They allow a child to organize, understand, and obtain feedback from the environment. Deafness affects those ego functions and modifies a child's experiences and interactions with the external world.[12] Mechanisms for internal control may not be well developed because of inabilities to communicate feelings and to delay, forego, or symbolically substitute desires.[13] Consequently, a poorly developed, loose superego, as manifested by impulsiveness and aggression, has been described in the deaf child.[12] Such behavior most likely represents developmental delay rather than psycho-

pathology,[14] because antisocial behavior is no more common in deaf than in hearing adults.[7]

Various authors describe a psychological profile of deaf individuals that consists of impulsiveness, egocentricity, rigidity, absence of creativity and inner controls, compulsiveness without accompanying anxiety and guilt, lack of empathy, and unawareness of the effect of their behavior on others.[1,13,15,16] Many of those traits are apparent during childhood and may be misinterpreted. For example, a deaf infant's withdrawal and blank facial appearance is a likely consequence of decreased sensory input, and as a result the child may be mistakenly labeled autistic or mentally retarded. Closer inspection, however, often reveals alert eyes that scan for activity in the environment.[15] Conversely, toddlers unable to express powerful drives and feelings may erupt into action or generate excessive activity[17] that may resemble hyperactivity or organic brain damage, although alternate periods of moderate activity are discernible.[15]

Prevalence figures of childhood behavioral disturbances are estimated to be as high as 40%,[18] although no increase in pathological states in deaf adults can be attributed to deaf childhood behaviors.[14] Lesser and Easser[15] mentioned the presence of narcissistic, histrionic, and obsessive-compulsive traits in deaf adults, but they dynamically differentiated these traits from those found in hearing individuals. For example, deaf adults may exhibit the obsessive-compulsive characteristics of rigidity, obstinacy, and dampening of emotional display, but they lack the shame, guilt, rumination, and anxiety present in obsessive-compulsive individuals. Deaf individuals may resort to rigidity and obstinacy because those approaches, which convey a degree of security and individuation, have been reinforced in their training of communication and discipline. Some residential schools, for example, foster narcissistic traits, such as egocentricity, by isolating the deaf child from the usual cultural constraints and coercions while excessively praising him for minor accomplishments.[13] Rigidity may be reinforced by hearing parents who, frustrated by their deaf child's limitations, resort

to restrictive or imperative methods of communication that do not go beyond the immediacy of the situation. Consequently, imagination and creativity, which are fostered by parents of hearing children during the "why stage," may not be optimized.[17] In fact, some experts argue that **the emotional reaction of hearing parents to their deaf child's handicap may have greater long-term consequences on the child than the actual hearing loss.**[16] The low incidence of other disorders, such as guilt-ridden, retarded depressions, has been linked to the impulsive tendencies of the deaf.[3,14] Depression, when present, is typically characterized by agitation with projection of hostile and aggressive feelings.[14] However, Rainer and colleagues, citing the unique process of deaf symbolization, questioned whether the underlying dynamics for neurotic disorders exist at all in deaf individuals.[19] It should be noted that little is known about this subject, which makes a diagnosis of neurotic conditions difficult.[7]

Communication and Cognition

A deaf child's language acquisition is estimated to be delayed by 3–4 years.[20] As the deaf child matures, linguistic and performance problems continue, with resultant cumulative deficits.[17] Schlesinger found **linguistic deficits mostly affect regulative, imaginative, and interpersonal functions.**[17]

MANUAL COMMUNICATION:

Speech instruction, a tedious process, is successful in only 25% of cases.[21] **Lip reading is even more difficult, and fewer than 10% of deaf individuals are solely dependent on it.**[14] **For those reasons, manual communication continues as the most common method of communication.** The predominant form, American Sign Language (ASL), appears to be concrete, fragmented, and syntax-specific and is more limited in vocabulary than spoken language.[12,22] **If interpreted literally or seen in written form, it can approximate the loosely associated communications found in schizophrenia.**[12] For example, the proper interpretation of the signed expression

"Mom, Dad top blow for touch finish car their" is "Mom and Dad are upset because I used their car." Signs and idioms vary regionally,[23] so care should be taken in viewing unusual signs or idiosyncratic expressions as psychotic "neologisms." The common difficulty of deaf individuals to symbolically communicate their feelings may mimic similar expressional difficulties found in schizophrenia. **Occasionally, exaggerated affective or physical attempts[24] to communicate feelings may be regarded as bizarre or inappropriate or may be confused with histrionic or aggressive disorders.** In an attempt to communicate her mother's anger, for example, a deaf client herself may appear to be enraged or out-of-control.

READING AND WRITING:

Linguistic deficits frequently contribute to poor reading and writing skills. Only 10% of prelingually deaf adults read above a fifth-grade level,[24] 30% are functionally illiterate,[7] and 90% have difficulty reading newspapers and magazines.[24] Koh et al.[25] pointed out that comparison studies of deaf and hearing individuals demonstrate the "powerful role of language with its rule-governed capacity for analysis, synthesis, encoding, and organizing of experiences and thoughts." Accordingly, **deaf clients may demonstrate limited concept formation, may be concrete, and may focus on that which is observable and tangible in the environment.[13]** Those cumulative deficits typically are evident in responses to verbally based measures of intelligence or to the cognitive testing portion of the mental status examination. Schizophreniform disorders, mental retardation, or organic brain syndromes are simulated when such cognitive limitations are coupled with seemingly disordered language, affect, and behavior.

COGNITIVE PERFORMANCE:

Several years ago, we, along with co-investigators Dooling, Gieseke, and Melman, undertook a comparison study of cognitive performances of deaf vocational-rehabilita-

tion clients and hearing psychiatric inpatients. Our group administered the commonly used cognitive portion of the mental status examination (WAIS subtests, Rochester format) to the prelingually deaf subjects. Deaf participants with histories of psychiatric disorders, organic mental illness, or mental retardation were excluded from the study. The majority of the subjects communicated through American Sign Language, although several used "signed English," which more closely resembles spoken English. An analysis of the deaf subjects' performances demonstrated **no significant difficulty with orientation, perception and coordination, or judgment.** Recent and remote memory posed few obstacles when questions about recent and past memories focused on personal activities; **subjects did not fare as well with impersonal general information questions,** such as listing recent U.S. presidents. **Almost all deaf subjects had difficulties with serial subtractions, general information, vocabulary, similarities, and, particularly, proverbs.** Although the better educated had less trouble with those items, their responses were still poor. **Deaf participants with less education had correspondingly poorer responses.** Those with minimal language competency—that is, with little or no communication skills—were unable to respond to cognitive testing questions and could easily be misperceived as being severely mentally retarded. **Except for the areas of perception, coordination, and judgment, the responses of the deaf subjects resembled those of organically impaired or thought-disordered psychiatric patients with normal hearing.**

Our findings are reminiscent of those from a study done by Singer and Lenahan,[26] who asked deaf and hearing children about dreams, fantasies, and play. **Responses by deaf children were unimaginative, concrete, and lacking in fantasies** when compared with responses of hearing children. It is likely that responses by participants in both studies reflect linguistic difficulties rather than psychopathology. Data by Furth[27] suggested prelingually deaf individuals are not retarded on certain cognitive tasks that emphasize symbolic thought, but they do not rely heavily on language skills. Vernon[7] supported that view, citing 50 investigations of performance-related I.Q. that found **deaf or hard-of-hearing individuals had the same distribution of I.Q. as the**

general population. Silver,[28] also refuting Singer and Lenahan's findings, cited his study in which art critics judged imagination, originality, and abstract thinking based on paintings done by hearing and deaf children, adolescents, and adults. He found deaf children and adults fared better in those areas than did their hearing counterparts, although deaf teenagers did not do as well.

Socialization

Cumulative linguistic problems affect a deaf individual's social integration and behavior.[12] In that regard, residential training programs may offer mixed blessings; they provide needed instruction and deaf role models but offer a protective environment in which children learn to adapt to others with similar handicaps rather than to hearing individuals in the external world.[29]

LeBuffe and LeBuffe[14] suggested the deaf person's rigid adherence to a given viewpoint may be a product of a restricted, regimented atmosphere in residential schools rather than from a lack of hearing. They, along with Lesser and Easser,[15] differentiated eccentricity, bluntness, aloofness, apparent crudeness, or lack of consideration for others from character pathology, believing that these behaviors simply reflect a lack of knowledge of etiquette. For example, deaf people are deprived of the potentially socializing and intellectually stimulating effects of media such as radio, television, and theater. They may be sensitive to the social stigmas of deafness and cautious in their interactions with hearing people, including professionals, for fear of being misunderstood, maligned, or mistreated. Deaf teenagers, in particular, experience difficulties with peer-group identification, role model dilemmas, and identity diffusion.[23] Many teenagers and adults feel more comfortable in their own subculture, which, some professionals argue, is natural and healthy.[7]

Associated Conditions

Coexisting organic deficits in a multiply handicapped deaf individual complicates assessment and increases the likelihood of psychopathologic problems. Many of the causes of deafness, such as maternal rubella, meningitis, and Rh incompatibility, are also primary causes of brain damage. The organic syndromes are grouped into five major etiologic categories: heredity, prematurity, maternal rubella, Rh incompatibility, and use of ototoxic drugs during pregnancy.[30] Of these, genetic or hereditary conditions are thought to be implicated in 30%–60% of cases of prelingual deafness.[7]

THE USHER SYNDROME:

One hereditary condition, the Usher syndrome, is believed to be transmitted by a single autosomal recessive gene with an incidence of 3 in 100,000 in the general population; in the subgroup of the deaf, the incidence is estimated at 3% to 6%.[31,32] Neuropathology, as demonstrated by abnormal electroencephalograms, epilepsy, multiple sclerosis, and other hereditary disorders affecting strength of movement, have been associated with the syndrome. The Usher syndrome has been associated with a high rate of mental retardation, and nearly 24% of individuals with Usher's have at least one psychotic episode, although the nature of the disorder is not well defined.[31] Additionally, the syndrome is characterized by moderate to severe congenital sensorineural hearing loss, vestibular hypofunction, and slowly progressive retinitis pigmentosa. Individuals who may have poor baseline functioning and periodic episodes of psychosis may be misdiagnosed as schizophrenic and treated with high doses of maintenance antipsychotics. However, the psychotic episodes typically are short-lived, stress-related responses caused by decreased stimuli that result from concomitant hearing and visual deficits. As such, the condition may respond to supportive psychotherapy, and psychotropic medications may only be needed to control acute symptoms.[33]

SURDOPHRENIA:

Surdophrenia, also known as "primitive personality,"[25] is a term initially ascribed by Basillier[7,13,24] to deaf individuals with normal intellectual potential who exhibit a combination of depression, aggression, and severely limited communication skills. They are particularly susceptible to stress and grossly overreact to mundane events in their daily lives. Organic brain deficits should be differentiated from surdophrenia and other functional or characterologic disorders.

MALINGERING:

The malingering of deafness is usually associated with attempts at litigation, evasion from military service, or for gain of compensation for injury. One recently hospitalized patient impressively displayed his signing skills and mimicked deaf behaviors. However, a certified interpreter quickly detected gross inconsistencies in his use of sign language and portrayal of deaf mannerisms. It was later discovered that the patient frequently used his "deafness," along with feigned depression and suicidal ideation, to gain food and lodging as he traveled across the country. Holm[24] described a reverse situation in which a prelingually deaf woman was fired from her job for "faking deafness." Her employer insisted she was not deaf because she responded to some noises and to her name. He was unaware that many deaf individuals, especially with the help of a hearing aid, can hear some sound but not well enough to discriminate speech. When doubt exists, ingenious audiologic tests can readily differentiate deafness from malingering.[29]

Assessment

Many deaf individuals are unfamiliar with the basic concepts of mental health and seldom seek assistance voluntarily.[6] Apprehensive and frustrated in their efforts to be understood, they are fearful of being labeled and may view professionals with

skepticism.[1,6,16] **Idioms, metaphors, and other symbolic forms of communication in psychotherapy tend to be poorly understood and unappreciated.** Deaf clients also will likely be less familiar than their hearing counterparts with client responsibility in therapy, and with psychodynamic concepts such as the observation that past experiences may dictate present or future behavior. Hoyt and coworkers, in their article on psychotherapy with deaf clients, comment on the possibility that the deaf may be reluctant to ask questions for fear that they may be viewed as ignorant or confused. As a result, **they may nod approval or understanding in order to mask their lack of comprehension. It therefore becomes useful to have clients repeat key points or relay their conceptualization of therapeutic issues.** Frustration, impulsivity, or anger may be apparent fairly early in therapy, especially if the therapist or counselor was viewed as a powerful figure who could quickly resolve longstanding misfortunes. Despite those obstacles, **Hoyt's group found deaf clients to be good story tellers and discovered their inexperience with therapy in many cases made them quite open to the process.** Many clients have also developed good coping styles because of the hardships imposed on them by their handicap.[6]

The therapist or counselor, on the other hand, may be affected by what Schlesinger and Meadow[26] described as "shock withdrawal paralysis" upon entering the silent world of deafness. As therapy evolves, optimal care may be compromised by taxing and exhausting difficulties with communication. The need is greater than with hearing clients for therapists to express themselves nonverbally and through facial expressions. Overall, **therapists often find a need to be more active and concrete,** especially with interpretations.[6]

If the therapist is unfamiliar with manual communication, other communication methods may present unique and specific problems. Since many deaf individuals have poor reading and writing skills, the exchange of written notes may not allow for sufficient clarity or understanding, or it may compound the client's insecurities about his poor reading and writing skills. **Complicating matters further,**

manual communication is a visual language, unlike the linear format of spoken English, with the client relying on visual constructs or images to convey ideas. Evaluations involving interpreters are also far from ideal. Hoyt and associates commented on the diluting effect of the interpreter on a therapeutic interaction.[6] The interpreter, as a third party, may be a distraction in therapeutic interactions and complicate issues of confidentiality.[22] As the center of attention, the interpreter may be seen as the one "understanding the client," thereby complicating transference and countertransference issues.[14] All these concerns are accentuated if the evaluator or therapist has meager or no sign language abilities. In such cases, the interpreter must modify the language so the evaluator or therapist understands fragmented sign language and the client understands the spoken words in sign language.[22] A study by Marcos[36] of interpreters translating for Spanish-speaking clients in mental health settings revealed distortions associated with the interpreters' language skills and psychiatric knowledge. The most frequently noted distortions were the interpreters' normalization of clients' thought disorders and disorganized statements. Similar interpreter-related distortions may be present during evaluations of deaf clients. Whenever possible, a certified interpreter with experience in mental health settings should interpret during the evaluation in lieu of family members or friends. Family members in particular may relay their perspective of the client's feelings or problems, may themselves be involved in the problem, and may not be sufficiently skilled in sign language. During the evaluation, rapport can be enhanced if eye contact is maintained and inquiries are directed to the client, rather than the interpreter. As a result, the therapist's powers of observation assume greater importance in the evaluation process as do the nonverbal behaviors of the therapist and the client.

Despite those varied obstacles, several measures can be taken to facilitate the assessment of deaf clients. The importance of obtaining a good history cannot be overemphasized. Since compromised communication makes this a difficult—if not impossible—task, psychiatric diagnosis is necessarily a prolonged process with deaf clients. Sources of information, in addition to family or friends, should include

community agency and residential school personnel who have worked with the client. Such personnel will not only be able to provide a different perspective of the client, but they also are helpful adjuncts to the evaluation and treatment process. More so than with hearing clients, deaf clients should be evaluated with their social situation and environmental setting in mind. Likewise, therapeutic goals should take into account the environment in terms of its ability to be altered or accommodating to therapy-related interventions.

In the evaluation of children, the parents' hearing status and educational environment should also be considered, because they influence self-image, maturity, independence, sociability, and sexual behavior. For example, Schlesinger[13] reported deaf children of deaf parents are better adjusted than those of hearing parents, and Mykelbust[37] found children less anxious in residential schools than in public schools. In children with impulsivity and behavioral disturbances, an EEG may be helpful in differentiating organic and functional pathology.[1]

MENTAL STATUS EXAMINATION:

On the mental status examination, behavior must be perceived in the context of deaf personality and socialization. Clients may be superficial or passively compliant and may respond inappropriately to inquiries for fear of being assessed unfavorably or embarrassed by their ignorance or confusion. The accompanying affect may be constricted, with inappropriate smiling intended to gain the approval of the interviewer. In frustrated clients, the mood and accompanying affect may appear agitated due to the use of aggressive or emphatic mannerisms to communicate feelings. In either situation, thought content typically reflects limited insight, because many deaf clients, unfamiliar with the concept that feelings influence actions, externalize problems onto their environment.[6]

As already described, the cognitive portion of the mental status examination will reveal language-related difficulties in several areas. Furthermore, American Sign

Language translation of the cognitive portion of the mental status examination can provide significant clues to the answers. Similar language-related difficulties have been reported with verbally based I.Q. and psychometric tests.[22] Donoghue and Bolton[38] found **that because of their clients' inadequate language skills, the Sentence Completion Test and the WAIS were too sophisticated for most of their deaf rehabilitation clients.** LeBuffe and LeBuffe[14] pointed out deaf individuals score below the general population on verbal-based intelligence tests, but they do as well or better than the general population on measures of nonverbal intelligence. **Mykelbust[37] reported pronounced schizophrenia scores on the MMPI's of college students with prelingual deafness and of individuals with acquired deafness.** He argued that the scores were **a result of inherent isolation resulting from deafness rather than evidence of psychosis.** The lower social introversion scores supported his arguments by showing that deaf individuals, unlike schizophrenics, were receptive to social contacts. On projective testing, American Sign Language responses may sufficiently differ from and not be as elaborate as spoken responses, thus being subject to different interpretations.[8] In general, many experts on deafness argue that almost any testing involves verbalization and therefore should be used with caution, if at all.[8,36,38]

PSYCHOLOGICAL TESTS:

Although **psychological testing generally is not valid for deaf clients, some global assessments are possible when appropriate subtests are administered by a psychologist familiar with deaf clients.** Donoghue and Bolton[38] reported success with the use of the Bender-Gestalt and the House-Tree-Person test as projective tools for the evaluation of social and emotional adjustment in their clients. **Intelligence is generally tested with nonverbal performance tests,** including the Ravens Progressive Matrices Test, the Revised Beta Exam, and the performance portion of the WAIS.[7,38]

SCHIZOPHRENIA:

The diagnosis of schizophrenia can be a difficult process, and diagnostic criteria may not be as reliable in deaf adults due to unique patterns of communication, cognition, and behavior. Evans and Elliott **identified nine primary symptoms of schizophrenia in deaf individuals as useful diagnostic criteria: loss of ego boundaries, delusional perception, restricted affect, illogicity, abnormal explanations, hallucinations, inappropriate affect, remoteness from reality, and ambivalence.**[39] Six other common symptoms of schizophrenia were identified as less useful because they are present in nonpsychotic as well as psychotic deaf clients: poor insight, lability of affect, poverty of content, poor rapport, vagueness, and inability to complete a course of action.

PERSONALITY DISORDERS:

Because little is known about personality disorders and neuroses in deaf individuals, **caution is indicated in diagnosis.** That is because personality traits have been stereotyped, other traits necessary for the diagnosis may be absent, psychodynamic issues vary from those present in hearing clients with similar traits and behaviors, and some of the characteristics of the suggested personality disorder may be related to or accentuated by the organic deficit causing the deafness.

Summary

Many behaviors and personality characteristics found in deaf individuals may relate to methods by which they cope and defend against the reactions of others and the hardships created by their handicap. The therapist's awareness of the communication problems, cognition, personality, and socialization of deaf individuals can help him or her better understand their unique problems. It behooves the therapist or counselor dealing with deaf clients to keep in mind Lesser and Easser's observation, "...that

which looks alike is not always the same; we must be aware of our underlying sets and biases in order not to form a trap of too easily reaching conclusions which preclude our fuller understanding of both the usual and the deviant."[15]

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QUESTIONS BASED ON THIS LESSON

25. Which of the following statements is correct?

    A. People with severe postlingual hearing impairment do not suffer with depression, isolation, and insecurity

    B. Hearing and speech are important for the normal development of object relations, in identity formation, and in control of affects and drive

    C. Deaf adults with obsessive-compulsive characteristics of rigidity, obstinacy, and dampening of emotional display are burdened with shame and guilt

    D. Narcissistic traits in the deaf, such as egocentricity, are the direct result of the handicap and never due to environmental influences

26. Which of the following statements is correct?

    A. Deaf children are never misdiagnosed as autistic

    B. The deaf person's frustration in attempting to communicate is never confused with bizarre, histrionic, or aggressive disturbances

    C. About 90% of prelingually deaf adults eventually read above a fifth grade level

    D. Because the American Sign Language method of manual communication appears concrete, fragmented, and syntax specific, it can be confused with the loosely associated communications found in schizophrenia

27. The Usher syndrome:

    A. Is a form of serious mental disorder named after Edgar Allen Poe's famous short-story, "The Fall of the House of Usher"

    B. Is a form of faking deafness seen in malingerers

C. Is believed to be transmitted by a single autosomal recessive gene, occurs in 3%–6% of deaf people, and is associated with a high rate of mental retardation and, in about 24% of cases, a single psychotic episode

D. Can be diagnosed by identifying deafness and psychosis in the same individual, is associated with a normal EEG, no history of epilepsy or multiple sclerosis, and the characteristics of an idiot savant

28. Compared with normal hearing children, deaf children tend to be:

A. Much more imaginative

B. Seriously impaired with regard to orientation and judgment

C. Able to achieve comparable IQ scores

D. None of the above

Directions in Rehabilitation Counseling

VOLUME 3 • LESSON 8

AIDS: Diagnosis, Treatment, and Management

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EDITOR'S NOTE

Under the Americans with Disabilities Act which went into effect in July, 1992, Item E states that the definition of disability "applies to individuals with AIDS and those affected by the Human Immunodeficiency Virus (HIV)." Since the HIV and AIDS-infected population is comprised mostly of working-age people, professionals in all areas of rehabilitation will be called upon increasingly to provide direct care for patients. Employers, too, will require considerable assistance as they encounter workers with AIDS.

Although the largest incidence of AIDS has been seen in New York and California, it can appear anywhere. While the disease is more common among men, a rising incidence among women world-wide has recently been observed. Male-male sex accounts for the largest incidence of AIDS with intravenous drug use being the next most common avenue of transmission. Because most cocaine addicts are also intravenous drug users, this high risk group is often responsible for a high number of infants born HIV-positive. A small percentage of these infants (9% of the total) develop the disease because of contaminated blood transfusions.

There are two diagnostic considerations: HIV infection, present when the blood test confirms contact with the retrovirus, and AIDS, the presence of a diagnosed disease. It's essential for counselors to be accurately familiar with the nature and course of these conditions, for while most of the rehabilitation strategies that they will employ are not unlike those they would use in any chronic, seriously disabling disorder, certain aspects are special to AIDS clients. In this lesson, the authors focus on these strategies, as they apply to the management of such cases through various phases—from the initial crisis and early adjustment, to the stage of acceptance and eventually preparation for death.

Introduction

There is no doubt that the impact of acquired immune deficiency syndrome (AIDS) throughout the United States and the world is the most crucial health issue in modern times. Current statistics are alarming.[1] Since AIDS was identified, 122,905 of 191,601 diagnosed patients have died in the United States. **Recent estimates are that 450,000 Americans will be diagnosed with AIDS by 1993.**[2] The data presented in Table 1 indicate the incidence of AIDS for selected states and territories.

As seen from the data presented in Table 1, **the largest number of AIDS cases in September, 1991 were found in New York and California.** However, the data do not suggest that rural states were not concerned about AIDS. **There were cases of AIDS reported in all states and territories, with the fewest reported in Guam (1) and South Dakota (2).**[3] Because of the contagious aspects of the disease, all regions of the country should address this issue with vigor.

TABLE 1

Aids Case Incidence for Selected States/Territories (through September 30, 1991)

STATE/TERRITORY	NUMBER
NEW YORK	40,127
CALIFORNIA	35,808
FLORIDA	17,805
TEXAS	13,526
NEW JERSEY	11,952
PUERTO RICO	5,986
ILLINOIS	5,638
PENNSYLVANIA	5,264
GEORGIA	5,258
MASSACHUSETTS	4,052
MARYLAND	3,806
DISTRICT OF COLUMBIA	3,158
OHIO	2,793

To better understand AIDS, it is essential to **identify characteristics of people who contract the disease.** The data presented in Table 2 summarize the current breakdown of AIDS as it relates to age, race, and sex. As seen from the data presented in Table 2, **nearly half of the people infected by AIDS are between the ages of 30 and 39 and are white. Almost**

TABLE 2
Acquired Immunodeficiency Syndrome (AIDS) Data for United States

Age	Number	%	Race	Number	%	Sex	Number	%
< 13	3,199	2	White	101,219	54	Male	166,774	89
13-19	715	< 1	Black	53,666	29	Female	20,121	11
20-29	16,999	20	Hispanic	30,113	16			
30-39	85,823	46	Other/Unk	1,897	1			
40-49	41,133	22						
50+	19,026	10						
TOTAL	186,895	100						

90% of people with AIDS are men, although recent reports indicate a world-wide increase in AIDS among women.

The data presented in Table 3 illustrates the exposure categories of people with AIDS. **The majority of people who contracted AIDS were exposed through male-male sex. The second largest exposure group comprises those exposed through IV drug use.** Initially it was thought that heterosexuals were not affected by AIDS, but as seen by the data presented in Table 3, **more than 10,000 people with AIDS are heterosexual.**

TABLE 3
AIDS Exposure Categories Data for United States (through September 30, 1991)

ADULTS/ADOLESCENTS

Population	Number	%
Male-male sex	110,678	(59)
IV drug use	41,963	(22)
IV drug use & Male-male sex	12,334	(7)
Hemophilia	1,597	(1)
Heterosexual contact:	10,636	(6)
w/IV drug user	5,635	
w/Bisexual male	614	
w/Hemophiliac	97	
w/Transfusion	217	
Other	4,073	
Blood transfusion	4,147	(2)
Undetermined	6,993	
TOTAL	188,348	

Because of the rise of drug abuse in the United States, health care workers witnessed children born addicted to cocaine. **Since many cocaine addicts are also intravenous drug users (IVDU), they are in a "high risk" group for acquiring AIDS. Thus, there was an increase in the number of infants who were HIV-positive when born.** The data presented in Table 4 indicated the AIDS exposure for pediatric categories.

As seen from the data presented in Table 4, **84% of the HIV-positive infants acquired the virus because their mothers had AIDS or were HIV positive. Nine percent of the infants were exposed through blood transfusions, and 5% suffered from hemophilia.**

TABLE 4
AIDS Exposure: Pediatric Categories
(through September 30, 1991)

Categories	Number	%
Hemophilia	156	5
Mother w/HIV/AIDS	2,738	84
Mother IVDU	1,337	
Mother sex w/IVDU	567	
Other	834	
Blood transfusion	281	9
Undetermined	78	2
TOTAL	**3,253**	**100**

Undoubtedly, rehabilitation counselors will encounter people with AIDS on their caseloads. Thus, it is the purpose of this lesson to familiarize rehabilitation counselors with the diagnosis, treatment, and management of AIDS.

Diagnosis

Rehabilitation counselors should understand that the diagnosis of AIDS is a medical concern and as such is determined by physicians through a blood test. Two diagnoses are involved: HIV infection and AIDS, or "fullblown AIDS." The appropriateness

of a diagnosis of AIDS is determined by the Centers for Disease Control (CDC), who defines it as:

> . . . the presence of a reliably diagnosed disease that is at least moderately indicative of underlying cellular immunodeficiency in a person without underlying immune deficiency state, on no medications that are known to cause immune suppression, and with no underlying malignancy such as lymphoma, which can cause immunosuppression.[4]

A person is diagnosed as HIV-infected when the blood test confirms that they had contact with the retrovirus. In 1986, it was reported that 5%–10% of those persons testing positive for the HIV will develop AIDS.[5] However, by 1991, it was reported that more than 90% of patients diagnosed as HIV-positive progressed from one stage of infection to another during a 3-year period. Thus, it appears best to conceptualize HIV infection as a chronic, progressive disease. An HIV disease continuum illustrates that infected persons may progress from being asymptomatic to symptomatic (thrush, fungal disease) to AIDS (complete immune system impairment). The symptomatic step on the continuum was previously referred to as an AIDS-related complex (ARC).[3] In conclusion, if rehabilitation counselors encounter people in whom AIDS is a factor, they should immediately refer the person to appropriate medical personnel for diagnosis. (Issues involving the stigma of an AIDS diagnosis will be addressed in the section on treatment.)

Treatment

Because of the dynamics of AIDS, it is crucial that a team approach be employed in working with people with the disease. The treatment of AIDS involves medical, legal, ethical, and psychological issues.

MEDICAL ISSUES:

Obviously, the best solution to the AIDS epidemic is prevention. Improved testing techniques of donor blood has substantially decreased the number of infections from blood transfusions. Additionally, education concerning safe sex and the sharing of needles for intravenous drug use was a factor in disease control. A search for a vaccine continues, and a new AIDS vaccine, HG-30, was tested in San Francisco. In addition, the AIDS Vaccine Clinical Trial Networks (AVCTN) is testing a vaccine called Env 2-3. This is the fourth experimental vaccine tested by the group.

While a search for a new vaccine continues, physicians are treating the symptoms with a variety of medications. Azidothymidine (AZT; Retrovir) was a step toward disease control. Rehabilitation counselors may contact the AZT Information Line (1-800-843-9388) or write the AZT Treatment IND Coordinating Center (Box 6042, Rockville, MD 20850) for specific information. Several new drugs such as Sandostatin, Fluorothymidine (FLT), ddI and ddC, and Procrit (epoetin, Alfa) are promising approaches in combating the disease.[6]

"SAFE" SEX:

Clearly, the practice of "safe" sex is critical in the prevention of the disease. Material available from the San Francisco AIDS Foundation (P.O. Box 42682, San Francisco, CA 94142-6182) provides a guideline for these activities. Practices considered safe are massage, hugging, cuddling, and mutual masturbation. Dry social kissing and body to body rubbing are safe, as well as practicing voyeurism, exhibitionism, and fantasy. *Possibly safe activities* include tongue kissing, vaginal intercourse with condom, anal intercourse with condom, and cunnilingus. Fellatio with condom, or fellatio without condom if stopped before climax, are also possibly safe. Unsafe practices include vaginal intercourse without condom, anal intercourse without condom, and blood contact, including menstrual blood. Also unsafe are fellatio without condom, semen or urine in the mouth, anilingus, hand in rectum, and sharing sex toys that have contact with

body fluids.[2] Rehabilitation counselors should be familiar with these practices and incorporate them into their counseling approaches—not only with people with AIDS, but with everyone.

LEGAL CONCERNS:

Issues involving AIDS testing are controversial and much debated. Some argue that all people should be tested for AIDS as a preventive measure. Others feel that test results are discriminatory and testing should remain voluntary. At the present time, AIDS testing is voluntary, and rehabilitation counselors must leave that decision to the client. Rehabilitation counselors may present testing as an option to high-risk clients, keeping in mind that the final decision to do so rests with the client.[7]

The federal government addressed the rights of people with AIDS in Public Law 101-336 (ADA, under Title 1: Employment Provisions). Under the definition of "disability" with respect to an individual, Item E states, "[It] applies to individuals with AIDS and those affected with the Human Immunodeficiency Virus (HIV)".[8] This group has the same protection as any other disabled group under the federal law, which went into effect July 26, 1992. The impact of the legislation is especially significant for rehabilitation counselors, because an overwhelming majority of the AIDS-infected population is of working age. Obviously, strategies must be developed to assist employers as they encounter workers with AIDS.

ETHICAL ISSUES:

Ethical issues involving AIDS focus on disclosure. An example of such an issue is whether or not a person infected with the virus informs his/her lover. The decision rests with the person infected. However, a man in Michigan, the first person charged under the state's AIDS disclosure law, was arraigned on the charge that he knowingly infected someone else with the AIDS virus.[9] The event suggests that this issue may change from an ethical to a legal issue in the future.

AIDS disclosure is an extremely difficult area because of the confidentiality of information obtained in the counseling process and the counselor's obligation to the community at large. For example, what would be the counselor's responsibility if he or she were counseling an infected person who was continuing to practice unsafe sex without disclosing the infection to his or her partners? It is not within the scope of this lesson to resolve these dilemmas—but merely to alert rehabilitation counselors to their existence. **The aforementioned example may provide a stimulus for a rethinking of confidentiality issues.**

STIGMA:

Stigma has long been a concern for rehabilitation counselors because of society's tendency to discriminate against people with disabilities. Frequently people with AIDS and HIV infection were referred to as part of the "gay plague."[2] The use of the word plague engenders fear and creates the negative spread effect of disability.[10] That is to say, people have the tendency to avoid anyone with the stigma. **It is the stigma that creates anxieties about disclosure and further complicates an already emotion-laden issue.** It is hoped the Americans With Disabilities Act will address the issue of stigma and prevent discrimination in the workplace.

Psychological Concerns

The psychological impact of having been diagnosed with HIV or AIDS is **devastating** for the client. **Therapeutic intervention is essential,** and it is in this process that rehabilitation counselors will be directly involved. **Initially, counselors assist clients as they process their feelings about the severe trauma.** The first concern is to **see that clients have access to appropriate medical treatment** for the disease. Following that, many critical issues may be addressed, such as **relationships with family and friends, employer reactions,** and **financial concerns.** Rehabilitation counselors should **perceive people with AIDS and HIV infections as severely**

disabled and use counseling techniques similar to those they would use with any client who has a catastrophic disability. It is crucial that counselors possess accurate information about AIDS so they can help their clients understand the condition.[7]

As stated previously, the disability can be perceived as involving several stages in a continuum. Thus, it is important for counselors to be able to identify accurately the client's stage of progression. A feasible approach for addressing the treatment of AIDS in such a continuous fashion categorizes the continuum into four stages: (1) Initial crisis, (2) early adjustment, (3) stage of acceptance, and (4) preparation for death.[11]

INITIAL CRISIS:

The initial crisis involves the circumstances surrounding diagnosis. Some of the problems arise when or if the person self-diagnosed his or her illness. In self-diagnosis, rehabilitation counselors should refer the client to a physician immediately.

The focal point of this first stage is the patient's reaction to the diagnosis. People facing a life-threatening illness typically react with periods of nonchalance, denial, and overwhelming anxiety. Further, it has been determined that patients vacillate among these periods as they move toward cognitive and affective integration of the event. It was also felt that these initial reactions provide an adaptive function in helping the individual fend off "too painful affects."[12]

The main objective during this stage is the establishment of the helping relationship, which will be no easy task because of the catastrophic dimensions of AIDS. It would be helpful for rehabilitation counselors to perceive this group as being severely disabled and employ counseling techniques similar to those they would use with clients experiencing traumatic diseases such as cancer. An equally important task for rehabilitation counselors is helping their clients address practical issues such as financial, family, and employment concerns.[7]

EARLY ADJUSTMENT:

It has been stated that once the initial shock of diagnosis passes, clients experience recurring periods of intense anxiety, anger, guilt, and self-pity. This is when the "roller coaster" phenomenon (i.e., the continual changes in emotional and physical functioning) is most apparent.[11]

During this phase, the rehabilitation counselor's role will be to help clients accept their disability. Clients' interpersonal relationships may deteriorate, and they may feel rejected by others. Rehabilitation counselors should be a "guiding force," assisting clients in their development of new coping skills. That sets the framework for clients' transcending their feelings of hopelessness.

Self-help groups seem to be especially beneficial during this stage by reducing social isolation and improving self-esteem. A cautionary note regarding self-help groups for this population is necessary, however.[11] It has been concluded that attendance at these groups is often traumatic for newly diagnosed clients. The client is exposed to accounts of the most upsetting aspects of their illness, and they see persons in all states of the disease. Thus, rehabilitation counselors must continue to provide supportive services for their clients, even though they have referred them to self-help groups. Examples of self-help groups for persons with AIDS are the Wellness Networks and the Shanti Project.

ACCEPTANCE:

Acceptance is the stage at which persons with AIDS achieve a new sense of equilibrium.[11] It's their life they accept, not their illness. At this time, clients focus on living rather than dying. Rehabilitation counselors should assist their clients in their quest to reexamine their lives. Through this process, clients are encouraged to find meaning in the trauma they are experiencing. For the most part, clients in this stage are experiencing quality living. However, counselors occasionally

may observe emotional regression. When this occurs, rehabilitation counselors must call to their client's attention the fact that this regression is detrimental to acceptance of disability.

PREPARATION FOR DEATH:

There are useful guidelines for rehabilitation counselors during this final stage.[11] It is important for counselors **not to be intrusive. Clients should determine when and how much the subject of death is discussed.** It is helpful to assume that clients have an innate sense of their condition and may know more than they have been told by their physicians. **Under no circumstances should rehabilitation counselors burden clients with unrequested medical or prognostic information.** Although there is hope, counselors should avoid giving clients false reassurances.

Rehabilitation counselors can **assist in such matters as planning powers of attorney, wills, and funerals or memorial services as well as providing support to survivors.** Rehabilitation counselors should assist persons with AIDS with final preparations for the inevitable event.[12]

SUPPORT GROUPS:

A variety of support groups on national and local levels can assist people with AIDS or HIV infections.[2] The Gay Men's Health Project and the Shanti Project in San Francisco are two examples. Many of the organizations are staffed by volunteers who assist patients in securing food, housing, clothing, medical attention, and emotional support. Rehabilitation counselors should consider these groups as a resource for their AIDS clients.

Management

Many of the issues involving management of AIDS were covered in previous sections. Rehabilitation agencies should prepare for the increasing numbers of people

with AIDS or HIV infections who will no doubt need rehabilitation services. An initial step would be to provide adequate training for counselors so they are better able to service this population. In addition, universities and colleges need to provide adequate curriculum so that graduates of their programs will have the expertise to work with this population. Workshops and conferences dealing with AIDS as a topic should be instituted as a means of disseminating current information about the disease. Furthermore, rehabilitation agencies need to function as client advocates for this group, because of the stigma involved. Client advocacy at all levels is crucial because of the stigma associated with AIDS.

Summary

AIDS is clearly a national health problem and requires extensive teamwork among health professionals, including rehabilitation counselors. Currently the symptoms of AIDS are treated with drugs while considerable research continues in the search for a vaccine. The epidemic proportion of AIDS will increase the numbers of people needing rehabilitative services. Rehabilitation agencies need to address issues in the rehabilitation process of people with AIDS and HIV infections through more extensive training of their staffs. Universities and colleges need to develop curricula that will prepare rehabilitation counselors to be effective resources for this population. Because of the stigma involved, client advocacy is very important, and rehabilitation counselors should accept the challenge to ensure against discrimination toward the affected population. In addition to special aspects of working with AIDS clients, the counseling methods for this population are similar to techniques used by rehabilitation counselors who work with with those suffering other catastrophic illnesses.

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Questions Based on This Lesson

29. Which of the following statements is correct?

    A. As the incidence of HIV infection and AIDS among heterosexual populations and especially women increases, its incidence among men homosexual and intravenous drug users has decreased substantially

    B. Most infants born HIV-positive have been infected by contaminated blood transfusions

    C. HIV infection involves "the presence of a reliably diagnosed disease that is at least moderately indicative of underlying cellular immunodeficiency"

    D. In 1991 it was reported that more than 90% of patients diagnosed as HIV-positive progressed from one stage of infection to another during a 3-year period

30. According to the authors, which of the following events is especially dangerous with regard to HIV infection and AIDS?

    A. Body to body rubbing

    B. Vaginal intercourse with condom

    C. Any blood contact whatsoever

    D. Voyeurism

31. In the category "stage of acceptance" described by the author as part of the continuum in the AIDS progression:

    A. The client struggles with realizing that he/she has a life-threatening disease, reacting with shifts in mood and mentation from nonchalance and denial to periods of overwhelming anxiety

    B. The client with AIDS finds a new sense of equilibrium and tries to focus on living rather than dying

C. Clients are likely to experience a deterioration in their interpersonal relationships, as they feel rejected and they go through a "roller coaster" phenomenon of anxiety, anger, guilt, and self-pity

D. Self-help groups are especially helpful now to overcome social isolation and help improve self-esteem, as the client prepares himself/herself to face imminent death

32. Which of the following statements is correct?

A. Rehabilitation counselors should never suggest that a client with AIDS consider making plans for his or her estate, consult an attorney, or talk about funeral arrangements

B. Self-help groups are especially useful during the final stages of AIDS as the client faces the immediacy of death

C. If a client with AIDS refuses to cooperate in taking measures to protect others from infection, counselors must immediately report such a client to regulatory authorities

D. In dealing with clients with AIDS, counselors should carefully familiarize themselves with all procedures required to protect them from infection

Directions in Rehabilitation Counseling

VOLUME 3 • LESSON 9

Vocational Rehabilitation in Schizophrenia

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EDITOR'S NOTE

Studies have shown that the success with which schizophrenic clients can sustain recovery and reduce the risk of relapse is critically related to their ability to assume meaningful lives in the community. Work is an essential component of such a life; however, because it somehow lacks the glamour of psychotherapy and the dramatic nature of symptomatic response to psychopharmacologic agents, career development has been a much neglected area in the treatment of these clients. In this lesson, the authors outline the process of vocational rehabilitation of schizophrenic clients, emphasizing that the field has become quite sophisticated in assessing and motivating these clients to take on work responsibilities as well as providing opportunities for work, such as sheltered work programs. Vocational rehabiliation counselors can evaluate and perhaps help clients who show even an inkling of interest in work, even at the prodding of the treating psychiatrist. Work therapy represents a carefully thought-through effort, with full attention to the person's previous work history and actual skills, and is not circumscribed by the client's career notions. Support and direction by experienced vocational counselors is vital. Mastery, self-confidence, a reduction in shame, and increased independence are several of the obvious benefits.

Introduction

Vocational rehabilitation for schizophrenic clients can bring a great deal of meaning to their lives. Referral of a client by a psychiatrist to a rehabilitation counselor may lead to successful placement and contribute to the client's well-being. This lesson provides a practical guide to the world of vocational rehabilitation, and describes the role of the vocational rehabilitation counselor and the collaborative relationship between psychiatrist and counselor.

Furthering Vocational Rehabilitation

Chronic schizophrenics encounter a number of obstacles in their efforts to become productive, functioning, contributing members of society. Sadly enough, the very professionals who are "helping" them frequently erect the barriers: mental health professionals often see these individuals as useless and incapable of doing productive work. To a large extent, lower-level or entry-level jobs and sheltered work activities are not considered worthwhile; there is much preoccupation with the "monotony" of routine work and the nonintellectual nature of nonprofessional work. **As a result, the benefits that derive simply from working—the feeling of being productive, the sense of being needed, the social outlet in terms of one's relationships with co-workers—are largely neglected.**

If work therapy is to be used to its fullest advantage, middle-class professionals need to guard against the tendency to view nonprofessional work in terms of their own subjective reaction to it. Concentrating on the aspects of work they themselves find dull, monotonous, even degrading, they often do not see that others may achieve a great sense of mastery and self-worth by success in whatever job is within their capabilities. Upward-striving, high-achieving professionals must recognize that their clients' values may differ from their own and that their clients do not necessarily

consider tasks requiring less cognitive skills demeaning. Doing any job well is generally highly regarded in circles other than those of mental health professionals.

For example, a young man recently discharged from a state hospital was able to leave a sheltered workshop after only 3 months and get a job as a dishwasher in a large, busy cafeteria. Understandably proud, he came to report this to his aftercare group. The response of the group leader was, "Isn't that great! That will help you to get a better job later." Insensitive to the patient's satisfaction, the professional, in a single sentence, destroyed his client's joy by implicitly downgrading the achievement.

Some Conceptions and Misconceptions

We believe that, to the extent possible, a day treatment center should not be used as an ongoing, lifelong resource for schizophrenic clients. The alternative, which is much more appropriate and does not foster regression and undue dependency, is one that **combines work therapy and social therapy in a mix that is tailored to the needs of each person.** Before we can use work therapeutically, however, we must wade through a number of misconceptions.

RELATIONSHIP BETWEEN WORK AND RECOVERY:

There is not, as many have supposed, a clear relationship between work capacity and degree of emotional recovery; that is, the ability to obtain a job and perform it does not require a certain degree of wellness. Some of the sickest and most disturbed people are able to work, some marginally and some with a high degree of competence. Also, it is often assumed that people have to be socialized before they are able to go to work, that they have to achieve a high enough level of social skills to get along with other people on some basis of reciprocity. Experienced clinicians know, however, that this is not necessarily the case. **Some clients can act appropriately within a structured work situation when cues are available to**

guide them but may be immobilized and confused by the lack of structure in a social situation. Others may achieve a high level of social skills but still be unable or unwilling to work.

RELATIONSHIP BETWEEN WORK AND SOCIAL SKILLS:

Work is seen by many clients as an activity that does not require them to exercise social skills. That makes it more comfortable than other activities. For instance, one client said,"On my job I don't have to be me." What she meant was that while she was working, the nature of her job defined her; she was a "cashier," and all her social anxieties could be put aside while she concentrated on the tasks of a cashier. She understood clearly what she had to do and felt competent to carry out the specific activities connected with the job. By contrast, she was lost in social situations where she saw herself as having to chart her own course and meet standards that seemed to her frighteningly amorphous.

A related and important point is that sometimes, for the person who is schizophrenic, stressing socialization is contraindicated. For example, a withdrawn young man had persistent difficulty in relating to others in social situations. He could, however, work effectively as an electronic assembler, because his interaction with other workers was minimal and could be limited to job matters. In the course of therapy, the client was encouraged to develop social skills and to try them out on the job. Within a short period, he had quit his job and required hospitalization. After some time, he was able to express the deep fears socialization had aroused in him because he could not determine what degree of socializing was appropriate to the various situations in which he found himself. He felt he had completely lost control and became so upset that he had to flee from the situation. The expectation that schizophrenics will learn to socialize is not always realistic; many have demonstrated they can function much better when not called upon to develop and use social skills.

Frequently, having gained a degree of self-confidence from being successful

on a job, schizophrenics can very gradually begin to devote their energies to performing better in social situations. For this reason, some are placed very early in a work situation rather than in a day treatment center or any other treatment requiring free social interaction with others. Such placement allows them to work on their interpersonal interactions gradually while engaged in a structured work task.

THE ROLE OF SHELTERED EMPLOYMENT:

Many disabled persons, for a variety of reasons, cannot be rehabilitated into regular competitive employment. They lack either the capacity or the will to meet the rigorous demands of most employers. For this group, sheltered workshops or other sheltered work arrangements are needed. An example of the latter would be an arrangement with a private employer in which a job in a factory or a store is performed by a vocational rehabilitation client accompanied by a counselor, who may at first help the client perform the work. Sometimes two clients may share one job, one in the morning and one in the afternoon. It is often the professionals, rather than the clients, who believe sheltered work is not good. Having a reason to get up in the morning, having a place to go where one can be useful and productive, earning money, having friends, and feeling accepted can be a tremendously important factor in the life of a person for whom the alternative is sitting in a board and care home watching television.

Nor can we assume that all schizophrenics will remain in need of ongoing sheltered employment. Some for whom we would predict little improvement will surprise us and ultimately go on to competitive employment. There should be no limit on how long schizophrenics can remain in a sheltered employment setting and no pressure on them to leave. When they are ready to move on, they find ways to let us know.

THE RATIONALE FOR WORK THERAPY:

Work therapy must have a well-thought-out rationale. Using work only to provide a daytime activity accomplishes little in the way of rehabilitation. **How serious and important therapists feel the work task is, and how they communicate their attitudes, consciously or unconsciously, to their clients, has a profound impact on the effectiveness of work therapy.** To begin with, professionals must maintain the same attitude whether or not the work involves competitive employment. If the tasks patients are doing are made to seem of little consequence, then they cannot see either the tasks or themselves as being valuable. Professionals communicate in verbal or nonverbal ways their reaction to low-level, low-pay jobs, and they need to guard against such disclosures in reacting to their clients' work activities. For most of their clients, work has been an important, integral part of their lives, and in our culture, our work still remains one of the major means by which we take our place in the mainstream of life.

Concepts Underlying Work Therapy

Work therapy is directed to the healthy part of the person. The aim is to maximize strengths and not focus on psychopathology. Work therapy focuses on reality factors rather than on intrapsychic phenomena and on changing behavior rather than on changing basic character structure. Work therapy can make the difference between a life of regression, dependency, and depression on the one hand and a life with considerable gratification and a sense of mastery on the other.

An example will illustrate some of these points. A workshop client is sitting at his work station hallucinating and not working. The trained foreman says to the client, "Stop talking back to the voices and get back to work." The foreman is talking to the well part of the ego. He is applying the concept of high but realistic expectations by conveying to the schizophrenic person that he is capable of being productive and is

expected to strive to realize his potential. He is emphasizing to the client his identity as a worker rather than as a patient. He is using a direct approach that reaches the client. He is helping the client achieve control. Further, he is indicating to the client that he cares about him instead of simply allowing him to sit there preoccupied with his psychotic symptomatology.

Whether we are talking about a sheltered work setting or some other work setting such as an entry-level job, we must emphasize that **in work therapy, it is important to understand that we are using sophisticated techniques even though at first they may appear simple.** Work therapy is often seen as nonintellectual by therapists unfamiliar with it; and, because it does not involve an intellectual discussion of psychodynamics, a superficial look at this type of therapy may confirm that opinion. However, important concepts underlie work therapy.

MASTERY:

Mastery is one concept of work therapy. Clients' feelings of accomplishment and their knowledge that they have been able to perform a task whose value is proved to them (because they have been paid money for it and because the work has resulted in a useful product) gives them a sense of mastery, a feeling that they are not powerless and helpless in the world. The dependent client role can be discarded gradually as the identity of "worker" is assumed. Contrary to what is thought in many circles, **clients *must* receive vocational counseling throughout this process** in order to give substance to what they are doing and to evaluate and consolidate their gains or losses. The counselor's role will be discussed in greater detail later in this lesson.

EXPECTATIONS:

Also involved is the concept of high but realistic expectations. This concept does not require that every schizophrenic achieve competitive employment. Rather, for

each person, the expectation is that he or she perform at his or her highest level of capacity. For example, in a sheltered workshop, if the highest possible level for a particular client is 50% of what workers in industry would be able to achieve, then 50% is a high expectation for this particular person. But if he or she is able to achieve 50%, we should not be satisfied—or let the client be satisfied—with 25%. **Schizophrenics respond to these expectations in a positive way in terms of both achievement and self-esteem,** and the professionals working with them need to communicate clearly what the expectations are. An attitude of high but realistic expectations tells clients in a meaningful way that others see them as more competent than they themselves supposed and that they are capable of achieving at a higher level.

The same principle of **high but realistic expectations** should be applied to the schizophrenic's behavior in any type of training or work activity. If we give the client the clear, consistent message that we expect a certain kind of performance and will not accept craziness, apathy, or a rationalization such as, "I can't do that, I'm handicapped," then we are likely to get a better level of performance and a healthier response. It is important that this attitude be enunciated as well as implied by our actions.

Vocational Rehabilitation Counseling

The attitude among some professionals that vocational rehabilitation counselors should play a relatively unimportant part, or no part at all, in the treatment of schizophrenics is fairly common. The basis for this point of view is the fact that a substantial percentage of these clients will not enter the competitive labor market. However, the intrinsic value of work therapy makes **quality rehabilitation counseling a necessity** whether or not the goal is regular employment. Certainly, how much counseling, what kind, and when it is used will depend on the needs of the individual client. This would be true in working with any client category. But work therapy attempted without the particular skills of a rehabilitation counselor has greatly diminished potential.

In what ways can the counselor work more effectively in this area than other helping professionals? It is true that **the function of counselor often seems indistinguishable from that of a psychotherapist. The important difference, however, lies in the counselor's orientation to the occupational aspects of life, his or her special knowledge in the field, and a focus on accomplishing behavior change with regard to work.** Purposely setting aside other areas of the person's life, the counselor focuses on vocational planning and vocational activities. The counselor's conviction is, however, that successes in these areas enhance other therapy and facilitate change in other facets of the person's life.

APPROPRIATE CLIENTS FOR REFERRAL:

Psychiatrists often ask, what kind of patient should be referred for vocational rehabilitation services? Counselors are apt to reply that **anyone who expresses any interest at all and who can get to a facility should at least have the opportunity to be considered for such services.** Assessment by a professional vocational rehabilitation counselor may bring different results than the referring psychiatrist might have expected. **Sometimes, patients who appeared to the psychiatrist to be questionable referrals seem highly appropriate in the judgment of the counselor, and vice versa. Counselor and therapist see schizophrenic clients from different perspectives. Moreover, clients may present themselves very differently to the counselor.** When schizophrenic patients see a psychiatrist in a psychiatric setting, they usually will conform to the role expectations of the environment and behave like patients, so their employment potential may not be evident. On the other hand, they may express a desire to work to their psychiatrists because they want their psychiatrists to perceive them as persons who want to work, although in actuality they may be extremely fearful of work and not ready to consider it. In their discussion about work with the vocational counselor, clients themselves may see these realities, or they become plain to the counselor.

TIMING OF REFERRAL:

Although referral of schizophrenic clients should be made as early as possible, it should not be made at an unpropitious time. Clients can derive little benefit from vocational rehabilitation if their energies are totally involved with a divorce, a separation, the loss of a loved one, or a major change in life style. The psychiatrist, however, should be sensitive to the very beginnings of recovery from crisis and **help clients become involved in work activity before they settle into a life pattern of apathy and inactivity.**

The vocational rehabilitation counselor will be involved with schizophrenic clients throughout the rehabilitation process. **In their early contacts, counselors probably will need to take a more active, authoritative role** than they would normally assume with their other clients. **It may be some time before severely disabled persons can take positive action on their own—and an even longer time before they allow themselves to believe that there is any hope that they can operate effectively.** A less active approach should, of course, be taken as soon as clients are able to take on self-direction.

INITIAL STEPS:

Following referral, counselors and clients will be assessing each other and working together to determine immediate plans. **Frequently for schizophrenic clients, the sheltered workshop is a good beginning.** At this point, the counselors' concern will be that the clients be clear about what they hope to accomplish in the workshop. Counselors will have **reviewed the clients' employment history** and will have **made some judgments about employment potential** as well as **which behaviors would have to be adjusted before successful and satisfying employment** could be reached. With these judgments in mind, counselors can help clients identify problems to be dealt with in the workshop. Counselors must be cautious in this determination and **plan for simple goals that clients will have no trouble reaching.**

CONTINUED MONITORING:

During the time the clients are in the workshop, **regular meetings with the counselors should be scheduled** so that progress can be assessed and new goals can be set or expectations reduced. Counselors should be very open with schizophrenic clients, because they will likely respond with a similar openness and deal with real issues. To illustrate, **a workshop client on medication that produces tremulousness if taken alone consistently came to the workshop without taking his antiparkinsonian medication.** He would say he had forgotten and would have to go home to take it, thus losing several hours of work time. The counselor felt free to say, "Several times in the past two weeks you have missed hours of work because you had to return home for your medication. I think you are trying to tell us you don't want to be here." With the situation clearly spelled out and in the open, the client could then discuss **his real concern—not really wanting to work, feeling resentful because he felt his wife and therapist were forcing him to come, and fearing that eventually he would have to face a job that was beyond his capabilities.**

Schizophrenics sometimes can tolerate only limited amounts of closeness, and contacts may be very short and limited to the workshop floor. **For instance, one client, who has now been employed for 4 years, was at first unable to tolerate as brief a period as 10 minutes in the counselor's office.** She would sit on the very edge of the chair and protest continually that she wasn't worth the counselor's taking any time with her. Because of her evident discomfort, the client was seen only during work, for a short conversation or greeting. **It was not until she came to the counselor's office and requested an appointment that regular interviews were set up.** Even then, they were never more than 15–20 minutes long. Eventually she was able to stay in the counselor's office without discomfort.

A rather common outcome of the client-counselor relationship in work with schizophrenics is **the discovery that a person who has the intellectual capacity or aptitude for certain careers has neither the emotional strength nor the personal-**

ity characteristics to succeed in those fields. **An in-depth knowledge of occupational requirements is necessary to reach and act on this conclusion.** Counselors are aware of the ingredients that make up the work environment of the various occupations and the essential personality traits required. Conversely, knowledge of the client will suggest to the counselor those **occupational fields that will be compatible with his or her personality.**

Sometimes this knowledge is used to reinforce the appropriateness of the client's current job, and psychotherapy can then focus on the real problems without resorting to "geographic therapy" (change of jobs). An excellent example of such reinforcement is a 42-year-old engineer who has schizophrenia and who had been in therapy since the age of 15. He had been able to achieve a very good employment history in spite of the severity of his illness. He was employed on an experimental electronics project, usually working alone in a situation that was low-key and relatively unpressured. He was referred for vocational counseling and testing to find another kind of work he could perform, because he believed a recent exacerbation of his illness was caused by his job. **Following counseling and a battery of vocational interest and aptitude tests, it was clear that the job in which he was engaged was uniquely suited to him. He and his psychiatrist then were able to explore other areas in his life and pinpoint why he was particularly troubled at that time.**

With many schizophrenic clients who express a desire to work, it will become clear that there is little or no possibility that work outside a sheltered setting can be considered. Here, the counselor's role will be to **alleviate anxiety about "not progressing"** and give support to the client in what he or she is doing in the sheltered work setting. In this instance, the counselor's attention to the details of a continuing evaluation reassures the patient of the value of his or her work activity. Furthermore, in this way, the door is left open for future spontaneous change and improvement that can occur even in very regressed clients.

It is noteworthy that some schizophrenic clients have articulated the belief that

going to work is their only way "back into society." **Working is so equated with normalcy in our society that it becomes a major criterion of "wellness."** For this reason, vocational rehabilitation adds another important dimension to the treatment of schizophrenics.

Interaction Between Vocational Rehabilitation Counselors and Psychiatrists

Wise psychiatrists are aware that they cannot be expected to have expertise in all areas, so most comfortably refer patients to specialists in other fields. Vocational counselors are outside of their own role in attempting psychotherapy, and they do a disservice to their clients if they attempt it. So it is with most psychiatrists who attempt vocational counseling and career selection; they are not serving their patients as well as they might by a judicious referral to a person with vocational rehabilitation skills.

In referring a patient for vocational rehabilitation services, some psychiatrists specify a particular activity: "Needs sheltered workshop," for example, or, "Place in training to be a landscape gardener's assistant." However, **better results can be obtained if the psychiatrist simply refers the person for a vocational evaluation and whatever services subsequently appear indicated. In this way, the psychiatrist allows the counselor and the client to work out vocational plans unhindered.** The client who arrives unannounced at the vocational services center, lunch in hand, and prepared to enter a sheltered workshop setting "because the doctor sent me," is rarely able to consider other plans without a great deal of difficulty. As already mentioned, clients may look almost totally different than they appeared to the psychiatrist, and a sheltered work setting may not turn out to be the best plan.

Somewhat along the same line is encouragement expressed by the psychiatrist of a particular vocational aspiration for the sake of supporting any positive activity on the

part of the client. Frequently, and understandably, the psychiatrist sees an interest in a vocation as a healthy sign, takes that interest at face value, and fosters it with no real discrimination. For instance, a person may say he wants to be an electronics technician, and the psychiatrist agrees that the idea is a good one. This endorsement from the psychiatrist without any determination of the client's fine finger dexterity, mathematical ability, patience with minute detail, or even possible color blindness, usually results in the client's adamantly pursuing that career selection no matter how inappropriate. Rather, the psychiatrist could have responded, "I'm glad to see that you are thinking along the lines of considering employment. Why don't you discuss this with your vocational counselor? She might also have some other ideas you would want to consider." In this way, the door would have been left open for other options. The rehabilitation counselor in consultation with the psychiatrist can be of great service by suggesting to the psychiatrist this approach at the onset of the partnership.

This is particularly appropriate when patient and psychiatrist have unrealistic ideas of the capabilities and readiness of the patient. A good example of this is a referral of a 47-year-old housewife with the notation, "Needs a job right away to get her out of the house." The woman had a 20-year history of multiple hospitalizations for schizophrenia and had not worked since she was 21. She had no work skills, appeared withdrawn and fearful, and had no idea of the kind of work she would like to do. She came prepared to have the counselor produce some magic results, and when these were not forthcoming, she gave up and did not keep further appointments.

Conclusion

Work therapy with schizophrenic clients can be an extremely effective activity that not only helps them remain in the community but also makes their lives more meaningful. It contributes to their mental health by increasing their feelings of self-esteem and mastery over their lives, and it often leads to their

achieving a greater degree of independence through employment. The use of vocational rehabilitation services in conjunction with appropriate ongoing psychiatric therapy considerably increases the efficacy of both treatment approaches.

Suggested Reading

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Questions Based on This Lesson

33. Which of the following statements is correct?

    A. Schizophrenic clients should be encouraged to pursue any work direction that appeals to them, without regard for their own particular vocational abilities

    B. The best way to identify a schizophrenic client's work abilities is assessment by a professional vocational rehabilitation specialist

    C. The ability to work depends entirely on the degree of behavioral improvement in schizophrenic clients

    D. A high level of social skills is required for schizophrenic clients to engage in any kind of work

34. Sheltered workshops and sheltered work arrangements are:

    A. Programs for work that exist only within psychiatric hospitals

    B. Places where schizophrenic clients can reside while being evaluated vocationally

    C. Exemplified by arrangements with private employers in which jobs are performed by clients accompanied by a vocational counselor who provides specialized support

    D. Always demoralizing to clients who feel that the conditions of work are contrived

35. For most schizophrenic clients, the vocational rehabilitation counselor should expect:

A. Achievement of competetive employment

B. An increased sense of mastery and self-esteem

C. Work in a sheltered workshiop or other sheltered work arrangement

D. Attainment of an upward-striving, professionally oriented career

36. Which of the following statements about vocational rehabilitation for schizophrenic clients is true?

A. Referral for such services should be made as early as possible, although not at an unpropitious time

B. In early contacts, the vocational counselor should always take a passive, nondirectional role

C. A sophisticated review of the client's past work history and an assessment of his or her skills are rarely required

D. Work therapy is really nothing more than an opportunity for clients to cultivate social skills

Directions in Rehabilitation Counseling

VOLUME 3 • LESSON 10

Private-Sector Rehabilitation

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EDITOR'S NOTE

During the last fifteen years, rehabilitation services have increasingly been provided by for-profit health organizations and professionals in private practice. Although there is substantial overlapping, the kinds of clinical situations counselors in this sector regularly encounter—and the particular skills they require to meet their responsibilities—differ somewhat from those seen in the public sector.

In the private sector, rehabilitation professionals often deal with adult clients whose physical impairments are largely the result of work-related injuries or auto accidents, and who also have associated medical and psychological problems. Thus, such counselors must possess a working knowledge of medical terminology and the medical conditions involved, as well as information about their treatment. Other valuable skills include job placement and job-seeking skills techniques, familiarity with workers' compensation legislation, facilitative counseling skills, and strong verbal and writing abilities. Private-sector rehabilitation professionals will be called on by organizations to help establish and maintain disability management plans, which include both education and program design and implementation.

Since services are rendered on a private basis, rehabilitation professionals usually rely on a fee-for-service arrangement. The principles of operating a small business should be mastered. Professionalism, the quality of the work performed, and the overall responsiveness of the counselor will significantly influence the extent of future referrals.

Introduction

The development and dramatic growth of rehabilitation in the private sector both contributes and attests to the professional status of rehabilitation counseling. In the private sector, the unique professional expertise, knowledge, and clinical skills of rehabilitation counselors are recognized by the general public and, accordingly, valued to the extent that they have become a marketable commodity. The existence of the private sector also acknowledges alternatives to the public sector for delivering rehabilitation counseling services.

The private rehabilitation sector emerged in the early 1970s as government and private industry struggled to control the skyrocketing expense of chronic disability, along with its associated medical and compensation costs. With this focus, private-sector rehabilitation has responded with valued skills that are directed toward valued outcomes for all concerned parties (injured individuals, employers, insurers, and health care providers). Indeed, **the hallmark of the rehabilitation counseling profession has always been to assist individuals with disabilities to become independent and self-sufficient. This philosophy fits very well with the desired outcome of controlling disability costs while enhancing quality of life.**

Over the past 20 years, private sector rehabilitation has grown tremendously, expanding into numerous private and public markets. **Some large corporations have developed extensive safety and health promotion programs, hiring or contracting rehabilitation counselors to provide such services. Also, workers' compensation, personal injury, and long-term disability insurance carriers have initiated claims monitoring and rehabilitation programs for catastrophic, chronic, or work injury cases that involve a disruption or loss of earnings.** These services are

also provided by rehabilitation counselors who are hired by an insurance company or are on contract from private rehabilitation agencies. Moreover, **governmental programs, such as the Federal Office of Workers' Compensation Programs, have developed referral networks** that use private rehabilitation counselors to control costs and optimize vocational outcomes for injured workers. Within various settings and markets, **the services that rehabilitation counselors provide may include assessment, job analysis, job placement, counseling, coordination with health care providers, negotiations with employers, vocational expert testimony, life care planning, long-term rehabilitation planning, and/or disability management.**

In this lesson, private-sector rehabilitation will *not* be considered synonymous with insurance rehabilitation. Rather, for the purposes of a broad discussion of private-sector rehabilitation, **this lesson will address an array of rehabilitation counseling services provided in the private, for-profit sector.** This is deemed appropriate, because one aspect of the increasing presence of private sector rehabilitation has been the establishment of private, for-profit programs providing similar services as public or nonprofit organizations. For example, **brain injury rehabilitation** and **industrial rehabilitation** programming are often provided by private providers. Also, **assessment and job placement services**, available on a contract fee-for-service basis, are also being offered by rehabilitation counselors working independently as consultants or as part of a private agency. Consequently, private rehabilitation has expanded well beyond the boundaries of insurance rehabilitation.

Prevalence of Private-Sector Rehabilitation

The prevalence of private-sector rehabilitation agencies and the specific characteristics of services provided varies considerably from state to state. **Workers' compensa-**

tion legislation, for example, influences the volume and demand for private rehabilitation services. Because some states require an injured worker to be referred for rehabilitation after a certain period of time, those states will require more services contracted from private rehabilitation providers. Notwithstanding, private rehabilitation providers exist in all 50 states.

Key Elements of Private Sector Rehabilitation

CLIENT POPULATION:

One of the distinguishing features of private-sector rehabilitation is the client population served. For the most part, clients served in private rehabilitation settings have physical impairments with associated medical and psychological problems. Because these physical impairments often were caused by trauma (such as work injury or motor vehicle accidents) and occurred during adulthood, many situational issues must be considered when assessing the functional impact of the injury and determining the course of rehabilitation. One of the variables that must be considered in rehabilitation planning is the status of disability compensation benefits and the potential secondary gain to the client from monetary payments, reduced work, and escape from social and familial obligations. Another variable that should be considered is the client's emotional reactions to the abrupt changes in his or her life.

CASE PROCESS:

Rehabilitation services applied in the private sector emphasize prompt and timely response; close communication with referral sources; small caseloads for intense, frequent contact with clients; and a business-like, professional atmosphere. Because services are rendered under a fee-for-service arrangement, services that

have been rendered must be documented and progress toward desired goals must be closely monitored. As is true in any service business, **future referrals are influenced by past responsiveness and quality of service.** Therefore, performance and results become the best benchmark for the continuation of the service.

Rehabilitation counselors can enhance case management and placement activities if they include interpersonal and vocational counseling in the case process. Addressing client concerns, fears, and frustrations through counseling can enhance rapport with a client and ultimately improve outcomes. Group and individual counseling—at least on a limited basis—should not be jeopardized for the sake of cutting costs if there is justification for the service.

Knowledge and Skills for Private-Sector Rehabilitation Counseling

Research has shown that rehabilitation counselors who practice in the private sector consider the following knowledge and skills areas to be the most important for effective practice:[1]

- **functional limitations of disability**
- **employability and transferable skill assessment**
- **job placement/job seeking skills techniques**
- **rehabilitation planning**
- **workers' compensation legislation**
- **professional ethics**
- **interpersonal communication skills**

- writing skills
- job analysis/modification
- job development techniques

Similarly, in a major study of rehabilitation counselor competencies, practitioners in the private sector—when compared with practitioners in the public and nonprofit sectors—had significantly higher levels of perceived competence in six of eight critical areas:[2] 1) vocational counseling, 2) personal adjustment counseling, 3) case management, 4) job placement, 5) consultation, and 6) job analyses. As such, counselors considering employment in the private sector should appraise and, if necessary, enhance their skills in the following areas.

ASSESSMENT:

Vocational assessment is a formal, multidimensional process that is ongoing throughout the counselor's involvement with a client. Overall, assessment of the critical issues for rehabilitation planning is achieved through a variety of means, including case file reviews, interviews, communication with health care providers, job site and home visits, formal testing, labor market analysis, and behavioral observations. The ability to translate information derived from assessment techniques into functional terms and the ability to assess the transferability of a client's skills for purposes of employability determination are two of the most highly valued skills for private-sector rehabilitation counselors.[1]

ANALYSIS OF FUNCTIONAL/MEDICAL INFORMATION:

Medical aspects of traumatic injuries and chronic disability are critical knowledge areas, because the majority of clients handled in private rehabilitation have

physical impairments. Persons with musculoskeletal injuries, chronic pain, spinal cord injuries, traumatic brain injuries, severe burns, and amputations constitute the majority of referrals to private rehabilitation. To assess and develop appropriate rehabilitation plans for such physical impairments, the rehabilitation counselor should have knowledge of the following:

- etiology
- potential complications
- specialized medical diagnostic and treatment protocols
- recommended therapeutic interventions
- functional implication
- long-term care needs

Because the rehabilitation counselor will be reviewing medical records and discussing treatment plans with medical professionals, a knowledge of related medical terminology is also essential.

COUNSELING:

Facilitative counseling skills are valued and frequently used by counselors working in private rehabilitation settings. Indeed, an analysis of graduates of master's degree rehabilitation counseling programs who work in public and private rehabilitation settings revealed that the counselors in private settings had retained significantly higher levels of faciliative counseling skills than counselors in the public sector.[3]

Returning a client to work as efficiently as possible is a primary private-sector rehabilitation goal. However, a client's own "perceived inability to work"

can erode self-confidence, lower self-esteem, and accentuate fears of the future. Counseling may be the primary tool to achieve the return-to-work objective. Counselors should encourage and guide the client to express frustrations and fears, clarify and modify expectations, develop realistic perspectives, learn problem-solving skills, improve communication skills, and develop a sense of personal responsibility and control.

CASE MANAGEMENT:

In addition to direct counseling and assessment interactions with clients, the private-sector rehabilitation counselor needs to be and **efficient, effective case manager and a coordinator of resources.** These are not new or unique skills for rehabilitation counselors, but are emphasized strongly in private rehabilitation settings. Oftentimes, making progress with complex cases is contingent on the counselor's negotiation and communication skills.[4] However, **the private-sector rehabilitation counselor should *not* attempt to function as a claims adjuster.** Rather, he or she is a professional consultant with specific assessment, counseling, case management, and placement skills for the management and resolution of complex cases within the boundary of ethical practice. **Negotiating skills of private-sector counselors, therefore, should not be motivated by the interests of an insurance carrier or other referral source**; rather, counselors should be professionally objective and facilitative, combining the resources of the client, the insurance carrier, the medical team, and the legal system toward a satisfactory outcome.

JOB ANALYSIS, JOB DEVELOPMENT AND JOB PLACEMENT:

"Return to work" is a critical component in most private-sector rehabilitation efforts. To achieve that objective, the following rehabilitation counseling skills are

required:

- **A thorough knowledge of the labor market**
- **An ability to analyze work tasks and settings comprehensively**
- **Skills in analysis of transferable skills (based on education, age, work, and volunteer experiences)**
- **Objectivity**
- **Sensitivity to *both* employee and employer perspectives about work**
- **Flexibility/creativity in designing placement plans**

For example, a gradual return-to-work plan may be the placement method of first choice for a particular client based on the counselor's job analysis and client assessment. That method, which includes thorough follow-up, allows the employer and employee to go through gradual "re-entry," avoiding the unrealistic, unattainable expectations that are inherent in an all-or-nothing dichotomy of "full return to work" (full work shift, regular duties, normal performance expectations).[4] **Such a gradual approach may be the most consistent with the physical/medical recommendations,** because it encourages a progressive work conditioning from both a physical and psychological perspective.

CASE REPORTING:

Effective **writing skills** are of paramount importance for rehabilitation counselors in the private sector. There is a definite need to document regular contacts and activities that relate to each case in order to prepare billings for reimbursement and to justify services and time utilization. In addition, **private-sector rehabilitation counselors are usually required to prepare comprehensive case reports** that analyze

referral information, pinpoint key rehabilitation issues, and summarize services and rehabilitation. Such reports require accuracy, comprehensiveness, and supporting documentation for any conclusions reached.

KNOWLEDGE OF THE BUSINESS WORLD

Private-sector rehabilitation is a business and often works with referrals from the business world, rather than from social service or educational organizations. It has been suggested, therefore, that private-sector professionals embrace a conceptual framework that allows for the balancing of complex clinical and business concerns.[5] **Rehabilitation counselors who start their own private rehabilitation agencies or perform independent consulting also need to be well-versed in the requirements of small business management.** Such topics may include legal requirements, accounting/fiscal management, payroll and employee benefits of businesses, federal and state reporting requirements, and taxation issues.

PERSONAL CHARACTERISTICS:

Some authors have suggested that **certain personal characteristics may be more compatible with employment in private-sector rehabilitation and, in particular, insurance rehabilitation.** Specifically, **service providers should have the ability and willingness to deal with: 1) A proportion of clients who may be suspicious and uncooperative; 2) insurance personnel whose primary motivation is cost containment; 3) restrictions imposed by lawyers, physicians, and insurance personnel; 4) travel involved in field visits to clients' homes;** and **5) documenting one's time in "billable hours."**[6] Rehabilitation counselors also need to strive for objectivity, sensitivity, attention to detail, and the ability to develop and implement

rehabilitation plans that incorporate multiple perspectives (e.g., client, family, employer, insurer, medical professionals).

Specialty Consultation Functions within Private-Sector Rehabilitation

In addition to counseling and case management, the private-sector provider may offer specialty professional consultation at the request of insurance companies, employers, the Social Security Administration, or the legal system. Specialty professional consultation may include expert witness testimony, disability management, and life care planning.

EXPERT WITNESS TESTIMONY:

Most legal definitions of disability reflect the importance of work in relation to normal functioning. For instance, in most workers' compensation cases, the percentage of disability is based on a consideration of both loss of bodily function and earning capacity. Disability insurance, including private disability and Social Security Disability Insurance and personal injury policies, also **define disability in occupational terms. Consequently, in such cases, percentage of disability is determined by an examination of the injured worker's pre- and post-injury earning capacity.** The legal system, the Social Security Administration, and insurance companies have increasingly looked toward individuals with training and experience in vocational rehabilitation to assess and render opinions concerning the vocational and rehabilitation implications of such cases.

Providing professional consultation regarding vocational and rehabilitation implications for legal cases is called vocational expert witness testimony. This professional role requires advanced assessment, report writing, and oral communications skills. Skills for vocational assessment in this context involve administering, scoring, and interpreting appropriate test instruments. In turn, it also requires synthesis of the assessed worker's vocational assets and limitations as they relate to occupational demands and opportunities in the available labor market. The private-sector rehabilitation counselor, who functions as an expert witness must possess objectivity, thoroughness, organizational skills, and effective communications skills. Vocational experts are often requested or subpoenaed to provide testimony before a judge, jury, or hearing examiner.[6] This process will thoroughly tap a counselor's verbal and organizational skills, since expert witness testimony is most effective and credible when presented logically and calmly, in understandable language, and with supporting documentation. Objectivity is the critical element for credibility, regardless of the source of referral.

DISABILITY MANAGEMENT:

Disability management is another specialty consultation role that provides a variety of opportunities for private-sector rehabilitation counselors. Disability management is a company-based, proactive system of policies, procedures and services for preventing illness and injury in the workplace, ensuring early identification and intervention for disability to minimize its impact, and providing timely rehabilitation approaches to facilitate safe, prompt return to work and to restore highest work capacity.[7] Rehabilitation counselors may provide consultation in the form of client assessment, psychosocial/vocational counseling, placement intervention, and employee educational programming, such as back protection or stress management

at the worksite.[8] Other services that are part of disability management include reviewing company rehabilitation procedures, developing and conducting in-house training programs on rehabilitation issues, or providing a critical review of disability cases for a specific employer.[9]

It is important for private-sector counselors working with disability management programs to recognize that businesses, just as individual clients, have varying needs. Therefore, an assessment of the individual business situation should precede the design of a disability management plan.[10]

The essential features of successful disability management programs include:

- commitment of top management
- education and involvement of employees at all levels
- union/labor participation from the start
- a coordinated team approach across departments
- active use of safety and prevention strategies
- systematic procedures for effective use of health care and rehabilitation services
- early intervention
- organized return-to-work program with supportive policies, modified duty options
- use of incentives and accountability to encourage participation
- a management information system to monitor incidents, benefits use, provider services, program costs, and outcomes

With these considerations in mind, disability management providers would be advised to tailor rehabilitation strategies and services toward aggressive early

intervention and be willing to customize services to the work environment of the specific organization being served.[11] It is useful for the rehabilitation counselor to consider these characteristics of successful programs when providing disability management consultation services.

LIFE CARE PLANNING:

Life care planning is another specialty service provided within private-sector rehabilitation. It can be viewed as an offshoot of assessment and case management, because a life care plan addresses the challenges and costs that are associated with catastrophic injuries. Rehabilitation counselors who have experience with traumatic injuries combined with formal training in medical, psychosocial, and occupational aspects of disability, as well as assessment and independent living knowledge, have ideal preparation for developing life care plans. The life care planning consultant must also have a working knowledge of rehabilitation technology and independent living aids and be aware of new resources that become available.

Summary

The professional identity of rehabilitation counselors who function in the private sector is of critical concern to the entire rehabilitation counseling community. The knowledge and skills required of professionals working in the private sector are, after all, grounded in basic rehabilitation counseling with additional emphasis in certain key areas. Potential conflicts exist for the counselor working in the private sector. For example, conflicting goals and objectives of referral sources and clients may place the counselor in a difficult "can't please everyone" position. However, it is

important for private-sector rehabilitation counselors to avoid perpetuating negative stereotypes toward injured workers and to resist taking sides.

The professional acceptance of private-sector rehabilitation counselors is also enhanced by active membership in professional organizations, attainment and maintenance of certification and/or licensure, adherence to ethical standards, and maintenance of the role of objective consultant. In order to function effectively in any setting, including the private sector, rehabilitation counselors must always maintain professional objectivity, standards, and ethics while continuing to expand the base of their knowledge and skills throughout their careers.

In the past 15 years, employment opportunities for rehabilitation counselors have experienced dramatic growth within the for-profit sector, and future growth in the private rehabilitation sector is likely. With increased medical and disability costs, growing emphasis on health promotion, and public policy shifts toward local community and private-sector solutions to social problems, the future of private-sector rehabilitation seems assured. Also, the **recognition of the long-term cost-containment benefits of short-term expenditures for rehabilitation services is an additional factor that will affect future referral patterns.**

Such factors have influenced, and will continue to influence, the development of private-sector rehabilitation. To meet the challenge, counselors working in the private sector must be thoroughly trained and appropriately experienced in the areas we have identified. Service providers must continue to strive to maintain professional ethics and standards—because in the private-sector arena, **results** and **accountability** are the primary hallmarks of viability and success.

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Questions Based on this Lesson

37. According to the authors, private-sector rehabilitation:

    A. Has proved to be an extremely costly way to provide services

    B. Has been exclusively restricted to insurance rehabilitation

    C. Often involves clients with physical impairments that start in adulthood, are caused by trauma, and are associated with medical and psychological difficulties

    D. Permits a much more leisurely approach to rehabilitation than in the public sector, since there is no need to document the services rendered and the time consumed

38. Which of the following skills is *not* specifically cited as a requirement for the private-sector rehabilitation professional?

    A. Job placement and job-seeking skills techniques

    B. Employability and transferable skills assessment ability

    C. Interpersonal communication skills and writing skills

    D. A willingness always to give testimony or provide reports that clearly benefit the individual or organization paying the bills

39. Which of the following counseling skills is *not* cited as necessary to achieve the goal of "return to work"?

    A. Thorough knowledge of the labor market

    B. Analysis of transferable skills

    C. Sticking adamently to existing placement plans and resisting pressures to be "flexible and creative"

    D. Sensitivity to both employee and employer perspectives about work

40. Private-sector rehabilitation professionals involved in insurance work should:

A. Recognize that they are dealing with an unusually naive and very cooperative group of clients

B. Be willing to visit clients' homes if it is helpful to their goals

C. Know how to set limits on insurance company personnel who seem to have no notion of what cost containment is all about

D. Largely ignore the restrictions that lawyers, physicians, and insurance personnel seem to impose and learn how to get around them all the time

Directions in Rehabilitation Counseling

VOLUME 3 • LESSON 11

Rehabilitation Counseling with Members of Minority Populations

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EDITOR'S NOTE

At no time since the beginning of the twentieth century has the composition of the United States been so drastically altered as in the past decade. Consider the population increases of the following groups since 1980: American Indians, almost 38%; African-Americans, more than 13%; Hispanics, 53%; and Americans of Asian descent, approximately 108%. Moreover, evidence reveals that racial and ethnic minorities now comprise a much higher percentage of the disabled population than of the nondisabled population. These increasingly pronounced demographic changes have profound implications for the rehabilitation profession.

The author points out that it is perhaps natural for rehabilitation professionals to be most comfortable with clients that are most like themselves. However, this is no longer possible or even desirable; because disabled persons from minority populations are no longer confined to specific geographical areas, all counselors must gain awareness of how differing cultural backgrounds can contribute to the uniqueness of each individual client, and thus to the rehabilitation process.

Statistically speaking, some values and experiences can be identified as characteristic of a particular culture, and may thus be useful in helping the counselor gain greater insight into the client's situation. However, the rehabilitation professional must guard against adopting these views unilaterally, and take care to regard each client as an individual who may have been influenced by these experiences to a great degree or not at all. That is, each client is unique. Adopting an increased sensitivity to and understanding of a client's different world view will profit the rehabilitation professional not only with minority populations, but in all dealings with all clients.

Introduction

Rehabilitation counseling, by definition, involves a relationship between counselor and client. Perhaps nothing is more frustrating to a counselor than to work with a client and have no obvious results or to find that the client is not responding. Equally frustrating is to have a client fail to return after one or two sessions. Although many reasons may explain this "failure to communicate," one particular reason may be that **the two participants in the process bring with them life experiences and perspectives that are fundamentally different in racial or ethnic background**. Beyond practical considerations, however, there is a larger ethical issue. Burn[1] suggests that "counselors are bound by professional and ethical obligations" to ensure that the counselor not "disregard world views other than the counselor's own." Katz[2] further points out the limits of counselors who hold only a monocultural perspective. The phenomenon of differing perspectives is likely to occur more often because of the **demographic changes** that have taken place in the United States during the past few years and that will continue to occur. These demographic changes affect directly those persons who will be served by rehabilitation counselors.

Until recently, clients of rehabilitation counselors in the United States usually had a race or ethnic background similar to the counselor. Counselor and client were thus much more alike than different in terms of cultural experiences and values. Additionally, counselors were trained in a relational process that was effective with a generally homogeneous middle-class client who fit the Euro-American ethos. It is perhaps natural that counselors are most comfortable with clients like themselves, or "identify clients who are culturally similar to themselves, as the most desirable with which to work."[1] Sue[3] has pointed out that **counselor preparation or training generally facilitates cultural encapsulation through "(a) the substitution of model stereotypes for the real world, (b) disregarding of cultural variations in a dog-**

matic adherence to some universal notion of truth, and (c) the use of a technique-oriented definition of the counseling process." Thus, rehabilitation counselors from traditional counselor education programs may already be at a disadvantage in recognizing how cultural background reflects attitudes. Not that the model of rehabilitation has been ineffective—Nell Carney, the current Rehabilitation Services Administration Commissioner, has attributed her success to the success of the public vocational rehabilitation system. More and more, however, clients will likely come from racial and ethnic minority populations. Sue, Arrendondo, and McDavis[4] suggest a need for a multicultural perspective for counseling and education in our society. Counseling, and rehabilitation counseling in particular, must begin to approach these clients from a new perspective.

This lesson will concern itself primarily with four groups in American society: African-Americans, Asian-Americans, Hispanics and Latinos, and Native Americans. It is recognized that there are many other ethnic subdivisions, many groups even within each of these four primary groups. One of the pitfalls related to counseling persons of any cultural/racial/ethnic population is to attempt to relate to persons in stereotypic ways. It should be emphasized that the lesson is an introduction to the process of understanding differing perspectives rather than an in-depth "how-to."

The primary objective for rehabilitation counseling is no different from that of any type of counseling activity, which is to become what Sue and Sue[5] term the "culturally competent" or skilled counselor. They identify three characteristics of culturally skilled counselors: First, they continually work to become aware of their own assumptions about human behavior, values, biases, preconceived notions, personal limitations, and so forth. Second, culturally skilled counselors actively attempt to understand the world views of their clients without negative judgments. Third,

culturally skilled counselors actively develop and practice appropriate, relevant, and sensitive intervention strategies and skills in working with clients.

Ethnic/Racial Disparities: A Comparison of Persons with Disabilities and Persons Not Disabled

The following information related to Hispanic Americans and African-Americans with disabilities suggests the **urgency with which rehabilitation counselors must become attuned and in touch with minority populations with disabilities.** As will be readily apparent from these figures, American society has failed to address the needs of citizens with disabilities who are members of minority racial/ethnic populations.[6]

The "typical" Hispanic-origin adult with a disability:

- is 43 years old
- is married
- lives in a metropolitan area
- is a high-school graduate
- is severely disabled
- does not work either full- or part-time
- had or has a blue collar job
- had a mean income from all sources of about $11,000 in 1987

The "typical" Hispanic-origin working-age adult with no disability:

- is 31 years old
- is married
- lives in a metropolitan area
- is a high-school graduate
- works full-time
- has a blue-collar job
- had a mean income from all sources of about $14,000 in 1987

The "typical" black working-age adult with a disability:

- is 47 years old
- is not married
- lives in a metropolitan area
- is not a high-school graduate
- is severely disabled
- does not work, either full- or part-time
- had or has a blue-collar job
- had a mean income from all sources of less than $9,000 in 1987

The "typical" black working-age adult with no disability:

- is 32 years old
- is not married
- lives in a metropolitan area
- is a high-school graduate
- works full-time
- has a blue-collar job
- had a mean income from all sources of about $14,000 in 1987.

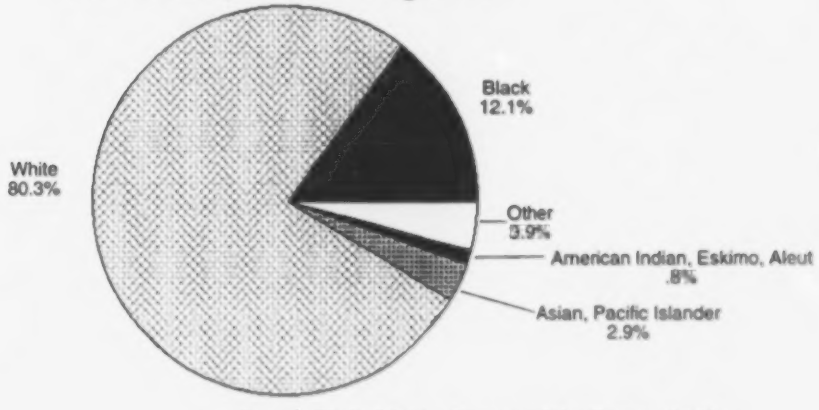
Comparisons with white Americans show even wider disparities in income and status.

The National Scene

Recently released figures from the U.S. Bureau of the Census suggest **significant changes in the racial and ethnic composition of the United States from the previous census just a decade ago. In 1990, almost one in four Americans had African, Asian, Hispanic, or American Indian ancestry, in contrast to only one in five in 1980.** At the same time, the proportion of **Americans identifying themselves as white declined to 80.3%.** The 1990 Census data indicate the U.S. population currently includes:

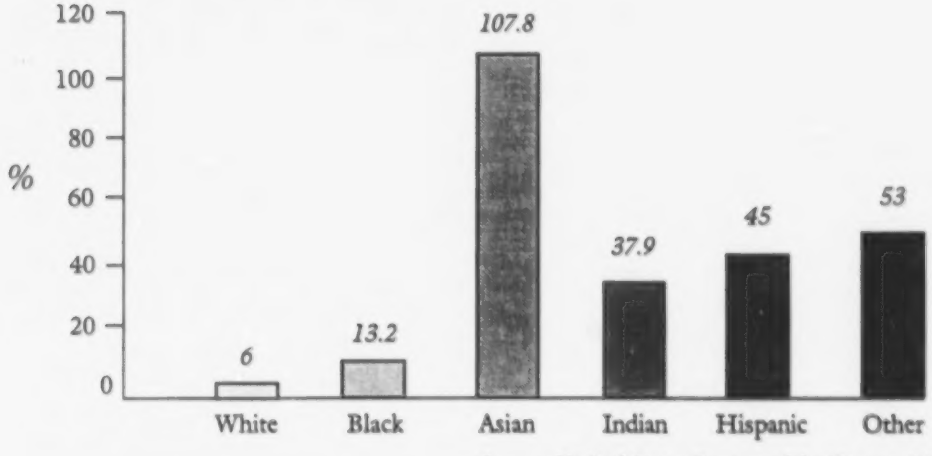
- 30 million blacks, an increase of more than 13% since 1980
- 7.3 million Americans of Asian descent, an increase of 107.8%
- 2.0 million American Indians, an increase of almost 38%
- 22.4 million Hispanics, an increase of 53%

FIGURE 1
U.S. Racial / Ethnic Composition



Source: United States Bureau of the Census, 1990.

FIGURE 2
Percent growth of U.S. Population, 1980-1990



Source: United States Bureau of the Census, 1990.

This unprecedented growth and the corresponding change in the racial composition of the United States will most likely continue. Estimates suggest that by the year 2000, 30% of Americans will be of a racial minority or Hispanic.[7]

Regional Changes

The aforementioned demographic changes are even more dramatic when regional areas within the country are examined. For example, California has 35% of the nation's Hispanics and 39% of the country's Asians. On the other hand, New Jersey has more Hispanics than either New Mexico or Arizona. There are more Asian-Americans in New York (694,000) than in Hawaii (685,000). Oklahoma has the largest Native American population, with 252,000, or 8%. Although 53% of African-Americans live in the South, the rate of increase was fastest in the West. Even though rehabilitation counselors in these areas must be prepared to work with clients of different racial and cultural backgrounds, counselors in other areas will need to be increasingly aware and sensitive as well.

This is especially true because disabled persons who are members of minority populations are no longer confined to specific geographical areas. For example, Southeast-Asian immigrants are now residing in many states, stemming from specific relocation policies of the U.S. government.

Immigration Patterns

Not only has the change occurred with regard to where ethnic and racial minorities live in the United States, but also where they come from originally. More legal immigrants came to the United States in the 1980s than at any time since the beginning of the twentieth century. In addition, illegal immigration has increased. Many of these immigrants are from Central America and Asia, and many are not skilled and have little formal education. Further complicating these immigration changes are specific differences among the various immigrant groups. For instance, immigrants from Asia came for primarily two different reasons. One large group

came from Asian countries that had already contributed fairly large numbers to the American population. Immigration was related to **family reunification** and was tied to kinship and already established social networks. The second large group of immigrants was from such Southeast Asian countries as Vietnam, Laos, and Cambodia. **These individuals did not come primarily by choice, but out of necessity, and thus have different needs. The supports available to these two groups vary tremendously as a result,** and rehabilitation counselors must be aware of these differences.

Disability and Minority Group Status

Although no major study of the use of rehabilitation programs by members of minority racial and ethnic populations has yet been undertaken, **anecdotal evidence**—as well as studies of other human service delivery systems[8]—**would suggest that minority populations have not been as well served as the majority.** At the same time, **members of ethnic and racial minorities are much more likely to experience disability.**[9] Although specific data are lacking, factors related to **increased probability for disabilities include: poor prenatal and perinatal care, inadequate nutrition and diet, greater risk for injury because of living conditions and types of employment situations, inaccessible health care, and a lack of proper health care knowledge and education.**[9] Walker and co-workers also found one in six persons with paralysis of the extremities to be black; in addition, the highest impairment rates for orthopedic disabilities, including the absence of extremities, occurred among Hispanics.[9] **These statistics have profound implications for work and rehabilitation.**

Even though Walker and colleagues[9] found no significant differences in the use of rehabilitation services among the racial/ethnic minority groups studied, they did report **significant differences in the use of counseling services** related to the voca-

tional rehabilitation process: 46% of whites report receiving counseling, whereas only 20% of African-Americans report receiving counseling. Evidence shows that **traditional counseling approaches and techniques, when applied to racial and ethnic minority populations, may be ineffective.**[4] Sue and associates[4] further point out that the profession of counseling often reflects the values of the larger society. Therefore, **two political realities must be addressed**:

> First, the worldview of both the counselor and client is ultimately linked to the historical and current experiences of racism and oppression in the United States. For the minority client, he or she is likely to approach counseling with a great deal of healthy suspicion as to the counselor's conscious and unconscious motives in a cross-cultural context. For the white counselor or helping professional, he or she is likely to inherit the racial and cultural biases of his or her forebears.
>
> Second, counseling professionals need to recognize that counseling does not occur in isolation from larger events in our society. All of us have a responsibility in understanding the political forces and events that affect not only our personal but professional lives as well.[4]

Figures cited in the annual report of the Department of Education Rehabilitation Services Administration[10] also suggest **lower participation in the state/federal vocational rehabilitation program**. For example, Asian-Americans comprised only 0.6% of the total rehabilitated by state independent living programs. As Smart and Smart[11] have suggested, **these underrepresented populations are overrepresented in physically demanding, dangerous occupations**. Rehabilitation professionals, especially counselors, must understand the cultural and racial differences of their clients and must be able to relate to those differences if vocational rehabilitation programs are to be effective and meaningful.

Pitfalls of a Monolithic Perspective

In discussing psychotherapeutic approaches for African-Americans, Lee[12] noted "the danger of assuming that all black people are the same and that one methodological approach is universally applicable in any therapeutic intervention with them." This caution should be the focus in understanding any minority cultural, ethnic, or racial population. Lee further suggests the need to go beyond "the impression that there is an all-encompassing Black reality and that all Americans of African descent act, feel, and think in a homogeneous fashion." As Pedersen[13] explained, **"No particular group is unimodal in its perspective."**

This is true regardless of the particular group. Hispanics in the United States can be of Mexican heritage or from Cuba, Puerto Rico, or one of the Central or South American countries. Americans of Asian descent may have ties to numerous ethnic backgrounds, as diverse as the Chinese, Japanese, Cambodian, Thai, and Korean. The term American Indian can be viewed as "an imposed social and political ethnic category with little relevant meaning," and represent "a range of cultural orientations."[14] **A major difficulty of many counselors is the tendency to lump together various populations and to relate to them based upon limited information and experience.**

In his attempt to find a theoretical base for a multicultural counseling perspective, Pedersen[13] proposed that "...the underlying principle of multicultural theory would emphasize both the culture-specific characteristics that differentiate and the culture-general characteristics that unite. The accommodation of both within-group differences, as well as between-group differences, is required for a comprehensive understanding of complicated cultures."

Pedersen further emphasizes the concept of accepting and examining *individual* difference, which has been a central idea in counseling within the context of cultural difference: "The cultural identities to which we belong are no more or less important than is our individual identity."[13] It is imperative that counselors give attention to both aspects of the individual so that counseling will be effective.

Barriers to Incorporating Diversity

Sue[15] identifies three major barriers to the incorporation of diversity:

- Differences in communication styles and differences in characteristics of racial-ethnic minorities
- Interpersonal discrimination and prejudice
- Systemic barriers

Some of the examples cited include for Barrier 1, the lack of assertiveness of some Asian-Americans; for Barrier 2, the stereotype that African-Americans make good athletes but are poor scholars; and for Barrier 3, the dominance of white men in positions of power. If we are to be effective as rehabilitation professionals, we must recognize the barriers that are built into ourselves and the system in which we function, as well as begin to look for ways to change ourselves and the system.

Skills for Multicultural Communication

An essential component of the counseling process is the communication between counselor and client. Skills for working with multicultural populations involve particular sensitivity. As Sue[15] has suggested, the counselor "must not only be able to communicate (send) thoughts, but also to read (receive) thoughts, recognize and respond to nonverbal messages, consider cultural cues operative in the setting, with the accuracy of communication tempered by appropriateness."

There are undoubtedly many different ways to obtain these skills or competencies. Leong and Kim[16] propose the use of multicultural sensitizers—alternative explanations of behavior often discovered through a group process in which people are able to "discover" their own "cultural myopia" or gaps in cultural knowledge.

In a similar manner, Speight, Myers, Cox, and Highlen[17] discuss the use of **"optimal theory"** to increase self-knowledge. Optimal theory assumes a unity of spirit and matter. As individuals are unique manifestations or spirit, self-worth is intrinsic and independent of external criteria. Under optimal theory, "self-knowledge" becomes the source of all knowledge. **A counselor who pursues self-knowledge comes to understand and appreciate others**. "As counselors come to understand fully who they are...they will be capable of valuing the richness of who their clients are."[17] This is the process of "bringing into conscious awareness one's self-assumptions, biases, thoughts, and feelings regarding oneself and others. As one engages in this process and comes to accept himself or herself, the way will be cleared for accepting and valuing others without the projection of one's own baggage."[17]

In addition, counselors must understand and be sensitive to the diversity of cultural/ethnic/racial differences of their clients if they are to be effective service providers, advocates, and counselors. For example, Smart and Smart[11] suggest **five cultural factors that may have an impact on the acceptance of disability by Mexican-Americans**. These factors are: **a familial, cohesive, protective society; a stoic attitude toward life in general; well-defined gender roles; religious views; and reliance on physical labor**. For all of the various populations, similar factors affect disability and the rehabilitation process.

Rehabilitation counselors must understand that outcomes may be influenced

directly by such culturally-based factors. **The perspective of disability and rehabilitation presented through traditional educational programs may not be an effective or appropriate process for persons from other backgrounds.** Smart and Smart[11] conclude that **successful rehabilitation will depend on broadening the concept of rehabilitation beyond a simple focus on the person with the disability, to the active incorporation of the social and cultural forces that surround the individual.**

Marshall, Martin, Thomason, and Johnson[18] further expand on the need for "culture-inclusive rehabilitation planning," as related to rehabilitation for Native Americans. However, the concept of culture-inclusive rehabilitation planning has applicability for any cultural/ethnic/racial population. Three particular elements were presented by Marshall and co-workers:[18]

- The use of the extended family in rehabilitation planning
- The influence of cultural practices related to social organization, health and medicine, religion, acculturation and language, on rehabilitation planning
- Acknowledgment of the potential interactive effects of gender, disability, and culture

Rehabilitation counselors who recognize that their clients may be influenced by their individual cultural backgrounds and work to accommodate their own perspectives to these differences will undoubtedly experience more positive outcomes than those who push forward while ignoring cultural elements that may be applicable.

Summary

As noted earlier, this lesson is designed to be an overview, rather than a comprehensive detailing, of some of the challenges faced by rehabilitation counselors when

dealing with a wide diversity of clients. Counselors are further encouraged to develop their specific knowledge, understanding, and sensitivity to the role ethnic and cultural backgrounds may play in the individual's experience.

Rehabilitation professionals also need to **become aware of their own cultural biases and understand the potential implications of these biases** when working with clients of different backgrounds and experiences. Although much of counselor training focuses on the self, **there has been a general lack of focus on what role cultural values play in interaction with clients**. Rehabilitation professionals also should be aware that **although few clients adhere strictly to classifications, typical client profiles tend to vary between racial and ethnic groups.**

Rehabilitation counselors need to **broaden their involvement**, both professionally and within their communities, to **include experiences that are multicultural in nature**. The ability to be open and sensitive is dependent upon feeling comfortable with persons who are different from ourselves. Rehabilitation counselors may have a "head start" over other professionals because they work with persons who are already different because of disabilities; however, they may need further understanding of how different cultural values may relate to disabilities.

A valuable way to gain a broader cultural awareness is to extend into areas that may not themselves be designed for counselors or rehabilitation professionals, but that entail becoming immersed into various cultural and ethnic populations. Given the fact that **individual differences are often more widely disparate than those between cultures**, the best strategy may be to approach persons of diverse backgrounds as **individuals with their unique experiences**, rather than rely on one's limited perception of what the client's cultural or ethnic experience has been.

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Questions Based on this Lesson

41. Which of the following is characteristic of a culturally skilled counselor?

    A. Categorically denying that he or she possesses biases or prejudice

    B. Abstaining from making judgments when attempting to understand the world view of culturally different client

    C. Disregarding cultural variations in clients

    D. None of the above

42. The ethnic group that experienced the largest increase in population between 1980 and 1990 was:

    A. Indians

    B. Hispanics

    C. Asians

    D. African Americans

43. According to the author, which of the following statements is correct?

    A. Many Southeast Asian immigrants came to reunite with families already residing in the U.S.

    B. Once immigrants belonging to minority populations assimilate into American culture, they generally use vocational rehabilitation services to the same degree as whites.

    C. Minority populations experience disability at about the same rate as whites

    D. Traditional counseling techniques are highly effective with all members of minority populations.

44. Which of the following is *not* an element of "culture-inclusive rehabilitation planning" as presented by Marshall and co-workers?

    A. Focusing solely on the individual with the disability

    B. Using the extended family in rehabilitation planning

    C. Understanding the influence of cultural practices related to social organization, health and medicine, religion, acculturation and language, on rehabilitation planning

    D. Acknowledging the potential interactive effects of gender, disability, and culture

Directions in Rehabilitation Counseling

VOLUME 3 • LESSON 12

Improved Detoxification from Drugs and Alcohol through Nutrition

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EDITOR'S NOTE

The role of nutrition in the rehabilitation of substance abusers (especially alcoholics) is a topic that has received increasing attention in recent years. Nonetheless, nutritional intervention remains a relatively overlooked method in the management of substance abuse today. A primary reason for the underuse of nutritional therapy is that most counselors are not trained specifically in nutrition's effects on the liver detoxification process. However, as the author indicates, one does not have to be an expert in nutrition to apply it in a rehabilitation context.

Dr. Bland and his colleagues have extensively researched the link between nutrition and the prevention of disease. In this lesson, he presents a straightforward discussion of the detoxification process. Although various therapeutic approaches to treating substance abusers have been shown to be effective, only through proper nourishment can the damaging physical effects of drug and alcohol detoxification be minimized. Accordingly, Dr. Bland highlights so-called "protector" nutrients and minerals that even aid in reducing withdrawal effects.

Knowledge of key nutrients and minerals is but the first step in using nutritional intervention as an effective therapy for substance abusers. It is indeed imperative to be aware of a substance abuser's history of drug, cigarette, and medication use; however, the client's current nutritional status should also be assessed. Once this is accomplished, a detoxifying diet can then be implemented for the client so that nutritional therapy can achieve optimum results. Dr. Bland includes a Metabolic Screening Questionnaire for nutritional status evaluation, a sample detoxification diet, and an 800 telephone number for more information on this diet, to help make nutritional intervention a practical therapeutic option for substance abuse counselors.

Introduction

Alcoholism and other substance abuse problems share many features, one of which is a relationship to poor nutrition. Because alcohol and other abused substances suppress appetite and alter food consumption patterns, the addicted person often displays poor nutritional status, which further impairs the proper absorption of nutrients and in turn exacerbates nutritional problems.

Furthermore, substance abuse has a distinctly adverse impact upon the body's detoxification mechanisms, which take place principally in the liver. Derangement of the detoxification process can result in an exposure to metabolites (breakdown products) of alcohol and other chemical substances, which further contributes to the physiologic addiction process.

The Pathophysiology of Substance Abuse

Alcohol and other substances of abuse are metabolized by the liver by a family of detoxification enzymes called cytochrome P450.[1] These liver enzymes are inducible: when a person is addicted to a specific substance, his or her body tries to compensate for the exposure by enhancing the level and activity of these enzymes. However, the liver simultaneously produces a class of secondary toxins called **oxygen free radicals. The production of these substances is associated with damage to the liver, brain, digestive tract and nervous system of the addict.**

The Role of Nutrition

To protect against the damaging effects of these toxic chemicals and the breakdown products of alcohol and drug detoxification, the body requires proper nourishment with various protector nutrients, such as vitamin C, vitamin E, and carotene (the orange-red pigment from fruits and vegetables such as carrots), as well as such minerals as zinc, manganese, and copper. Adequate intake of dietary protein is also very important to help support the body's proper detoxification pathways.[2]

With proper nourishment, the damaging effects of the detoxification process are minimized, and the withdrawal effects during the "drying-out" period are reduced. Many therapists have found that those who are addicted to alcohol and other substances can experience improved success in a treatment program if they are properly nourished with the protector nutrients, the B-complex vitamins, and magnesium. Doses of nutrients that have been employed for this use are listed in Table 1.

TABLE 1
Nutrients Appropriate for Those Undergoing Detoxification

200 IU vitamin E
1000 mg vitamin C
10 mg carotene
10 mg vitamins B_1, B_2, and B_6
50 mg vitamin B_3
20 µg vitamin B_{12}
400 µg folic acid
20 mg zinc
2 mg copper
5 mg manganese
400 mg magnesium
70 g high-quality dietary protein

Improvements in nutritional status enable the liver to perform its function in detoxification without damage to the body from the toxic effects of oxygen free radicals. The reduction of toxic substances through improved detoxification also results in lowered addiction potential.

Nutritional intervention is an often-overlooked tool in the management of substance abuse. Because most therapists are not trained in nutrition and its effects upon detoxification, application of this important adjunctive method of therapy is not included in the comprehensive client management plan.

Fortunately, the therapist need not be an expert in nutrition to apply this nutrition concept. Over the past 4 years, we have been involved in the development and evaluation of a simple and effective nutritional intervention program to assist in liver detoxification. Once understood, this program can easily be applied to clients who may suffer from a variety of substance abuse problems. It can be integrated within all traditional approaches to managing substance abuse in order to improve program success, lower recidivism, and reduce the adverse health effects associated with substance abuse and its treatment.

Evaluating Nutritional Status

We have devised a method to evaluate liver function with regard to detoxification. With this information, the nutritional component of the treatment program can be implemented. Its success can be followed by an evaluation of the program's effect on the liver's ability to detoxify toxic substances and render them ready for excretion. The test requires the client to consume a standard dose of caffeine in purified form along with a measured dose of sodium benzoate, a common food preservative that retards mold growth. Saliva samples are taken at 2 and 14 hours after the caffeine administration, and urine is collected for 4 hours. The saliva samples are tested at the laboratory (MetaMetrix Laboratory, Norcross, Georgia) for caffeine levels and the urine for hippuric acid, the detoxification product from sodium benzoate. **The more rapidly**

the caffeine disappears from the saliva and the more hippuric acid excreted in the 4-hour urine sample, the greater the rate of detoxification.[3,4] This protocol has been used extensively in our studies to evaluate liver detoxification status and to follow the success of a nutritional intervention program designed to improve the effectiveness of a treatment program.

Altered test values for either caffeine or benzoate reveal modified or ineffective detoxifying function of the individual's liver. Indications of poor detoxification ability is predicative of a more difficult course and the potential for compliance or outcome. Recent studies indicate that those individuals who have multiple chemical or substance abuse exposure may have an even more difficult time in detoxification. **Drugs, alcohol, cigarettes, and medications all work together to alter the detoxification ability of the liver; these complicating factors make it even more important to implement a nutrition intervention program.**

The Detoxification Diet

We have developed a specific diet that is high in nutrients known significantly to improve or "upregulate" the detoxifying capability of a liver that has reduced functional liver capacity. Earlier studies had already shown that diet is very important in the regulation of cytochrome P450 and that it can also be affected by the amount and type of protein, fat, and carbohydrate in the diet. Other research had revealed that specific vitamins, minerals, and conditionally essential nutrients, such as glutathione and the amino acid L-cysteine, can influence liver detoxification.

We conducted a 21-day, placebo-controlled intervention trial to evaluate the effect

of this nutrient-tailored diet on the liver's ability to process foreign substances and prepare them for excretion. The caffeine and benzoate tests were used to evaluate liver function during this study. The test and placebo diets were very similar in calories but differed in the level of specific nutrients recognized to help support improved liver detoxification.

Participants were evaluated before and after the test diet or placebo intervention by the caffeine and benzoate tests. The physical signs and symptoms experienced by the participants in this study were evaluated using the **Metabolic Screening Questionnaire (Fig. 1). Scores greater than 100 points on the questionnaire are indicative of significant toxicity problems needing nutritional support, whereas scores between 50 and 99 points indicate moderate health problems associated with metabolic toxicity**. The questionnaire is derived from the Cornell Medical Index, a well-respected medical evaluation instrument, and has now been used with several thousand people going through a detoxification program to follow the success of the program.

The results of this placebo-controlled diet intervention program were quite remarkable. **Before the diet intervention, the liver detoxification ability of both the test and placebo groups was slightly abnormal. After intervention with the diet for 21 days, however, a statistically significant difference ($p<0.05$) between the test diet group and the placebo group was seen. The test diet group showed improved liver detoxifying ability not seen in the placebo diet group**. This improvement was also mirrored in the improvement in the self-rated symptoms, as measured from the questionnaire. The initial symptom scores from the questionnaire were the same in both the test and placebo diet groups, but after diet intervention, only the test diet group had a significant reduction in health complaints.

FIGURE 1
Metabolic Screening Questionnaire

Rate each of the following symptoms based upon your health profile for the past 30 days

POINT SCALE
0 = **Never or almost never** have the symptom
1 = **Occasionally** have it, effect is **not severe**
2 = **Occasionally** have it, effect is **severe**
3 = **Frequently** have it, effect is **not severe**
4 = **Frequently** have it, effect is **severe**

DIGESTIVE TRACT	_____	Nausea or vomiting	
	_____	Diarrhea	
	_____	Constipation	Total
	_____	Bloated feeling	_____
	_____	Belching or passing gas	
	_____	Heartburn	
EARS	_____	Itchy ears	
	_____	Earaches, ear infections	Total
	_____	Drainage from ear	_____
	_____	Ringing in ears, hearing loss	
EMOTIONS	_____	Mood swings	
	_____	Anxiety, fear or nervousness	Total
	_____	Anger, irritability, or aggressiveness	_____
	_____	Depression	
ENERGY/ ACTIVITY	_____	Fatigue, sluggishness	
	_____	Apathy, lethargy	Total
	_____	Hyperactivity	_____
	_____	Restlessness	
EYES	_____	Watery or itchy eyes	
	_____	Swollen, reddened or sticky eyelids	Total
	_____	Bags or dark circles under eyes	_____
	_____	Blurred or tunnel vision	
		(does not include near- or far-sightedness)	
HEAD	_____	Headaches	
	_____	Faintness	Total
	_____	Dizziness	_____
	_____	Insomnia	
HEART	_____	Irregular or skipped heartbeat	Total
	_____	Rapid or pounding heartbeat	_____
	_____	Chest pain	
JOINTS/ MUSCLES	_____	Pain or aches in joints	
	_____	Arthritis	Total
	_____	Stiffness or limitation of movement	_____
	_____	Pain or aches in muscles	
	_____	Feeling of weakness or tiredness	

Relationship of Toxicity to Health Problems

The study results point to an important relationship between improvement in liver detoxification ability and the decrease in chronic health problems and symptoms associated with toxicity. It is important to recognize that a number of contributions to toxicity symptoms may exist in the addicted. **Long-term consumption of excessive alcohol,** for example, **is known to damage the sensitive lining of the intestinal tract,** allowing absorption into the body of toxic substances that may further aggravate toxicity symptoms.[5] **Substance abuse can also alter the types and numbers of toxin-producing bacteria in the intestinal tract, which can contribute to alterations in brain function and cognitive behavior. The liver is very important for "cleansing" the blood of these toxins before they can reach the brain and alter brain chemistry. Therefore, if the liver's detoxifying function is impaired, the result is increased damage to the nervous system.**[6]

Substance abusers may also become more "allergic" as a consequence of the damaging effects of toxins upon the immune system. **Health problems, such as irritable bowel syndrome, eczema, and arthritis are all associated with the toxic burden** that accompanies alteration in digestive and immune function in substance abusers. **Avoiding foods that tend to produce food intolerance symptoms—such as dairy products, cereal grains other than rice, yeast, shellfish, and citrus fruits—may help bring relief of symptoms in those suffering from these disorders.** Hunter has pointed out that alteration of digestive function and intestinal bacteria may alter liver function as a result of the release from toxic bacteria of substances that alter immune function and could result in symptoms of arthritis.[7] Even the appearance and progression of nervous system diseases may be the result of exposure of the nervous

system to toxins that were not properly detoxified by the liver. Steventon and his colleagues found that those who had Parkinson's disease had significantly reduced liver detoxification ability. From their work, they concluded, "Parkinson's disease patients may be unusually susceptible to exogenous or even endogenous toxins."[8]

In our work, we found liver function in a group of nondiseased persons to vary widely when evaluated by the caffeine and benzoate tests. This variation of liver detoxifying ability may be linked to the susceptibility of a substance abuser to the secondary health effects associated with drug and alcohol problems.

The Detoxifying Diet

Because a tailored diet can improve liver detoxifying ability, this nutritional intervention program is believed not only to help improve the success of a treatment program but also to **reduce the health risks associated with substance abuse.** By using a diet that supplies readily digestible high-quality nutrition that is high in specific nutrients supportive of detoxification, a significant improvement in both digestive function and liver detoxifying ability can be realized.

This unique detoxifying diet makes use of specific nutrients that improve digestion and assimilation of nutrients while providing the important nutrients in the correct level to help support the body's natural detoxification process. In a sense, this diet might be considered to fit the definition of a medical food. A medical food differs from traditional food by supplying specific tailored nutrients at levels that can support unique physiological processes associated with certain health needs. The diet composition of the program for detoxification is shown in Table 2 on the following page. **It should be noted that this diet supplies not only adequate calories and levels of the essential**

vitamins and minerals but also special nutrients such as the aminoacid L-cysteine, glutathione, and molybdenum, which have been shown to be very important for the liver's detoxification process.[9] An example of the application of the diet is shown in the 4 days' menu plan described in Table 3. (A more complete description of the 21-day diet plan and nutritional formula can be obtained by calling 1-800-843-9660).

TABLE 2
The Nutrient Composition of the Two Base Powdered Meal Supplement Products

Nutrient	*Test*	*Placebo*
Calories	450	300
Protein	45 g	30 g
Carbohydrate	51 g	40 g
Fat	9 g	2 g
Fiber	6 g	8 g
Sodium	180 mg	320 mg
Potassium	1260 mg	1380 mg
Vitamin B_1	6 mg	1.1 mg
Vitamin B_2	6 mg	1.2 mg
Vitamin B_3	21 mg	14 mg
Vitamin B_6	10.2 mg	1.4 mg
Vitamin B_{12}	10.8 mg	4.2 mg
Folic acid	240 mg	200 mg
Pantothenic acid	10.5 mg	7 mg
Biotin	405 mg	210 mg
Vitamin C	900 mg	42 mg
Vitamin A	15,000 IU	3500 IU
Vitamin E	324 IU	22 IU
Calcium	600 mg	500 mg
Magnesium	420 mg	200 mg
Iron	10.8 mg	12.6 mg
Zinc	30 mg	10.5 mg
Copper	3 mg	1.4 mg
Phosphorus	600 mg	500 mg
Manganese	3.9 mg	2 mg
Selenium	120 mg	60 mg
Chromium	150 mg	134 mg
Molybdenum	360 mg	100 mg
Iodine	159 mg	105 mg
L-Glutathione	10 mg	—
L-Cysteine	5 mg	—
N-Acetyl Cysteine	5 mg	—

The diet can help improve the conversion of toxic substances in the liver to nontoxic materials that are prepared for excretion in the urine or bile. Because this diet has been demonstrated to help in several of the liver's detoxification processes, including cytochrome P450 as well as conjugation activity, it helps to convert substances to less-toxic byproducts. This is very different from the effects of certain drugs or alcohol, which activate cytochrome P450 but do not improve the function of the conjugation steps. Therefore, drugs and alcohol may increase the body's toxic reaction, because the intermediate substances produced by

TABLE 3
Sample Diet, Days 1 through 4

	DAY 1
Breakfast*	Test diet formula
Snack #1[§]	Apple or papaya
Lunch*	Test diet formula Carrot and celery sticks
Snack #2*	Test diet formula
Dinner*	White rice Peas and zucchini
Snack #3*	Pears (fresh or canned without sugar)
	DAY 2
Breakfast	Test diet formula
Snack #1	Pear(s)
Lunch	Test diet formula White rice
Snack #2	Test diet formula
Dinner	Baked sweet potato or yam Green beans Sliced cucumber
Snack #3	Banana
	DAY 3
Breakfast	Test diet formula
Snack #1	Peach(es)
Lunch	Test diet formula White rice
Snack #2	Test diet formula
Dinner	Baked winter squash Steamed broccoli or cauliflower
Snack #3	Kiwi fruit
	DAY 4
Breakfast	Test diet formula
Snack #1	Melon
Lunch	Test diet formula Carrot and celery sticks
Snack #2	Test diet formula
Dinner	White rice Peas and zucchini Broccoli
Snack #3	Kiwi fruit

8 a.m.*
10 a.m.[§]
noon *
3 p.m. *
6 p.m. *
8 p.m. *

the action of cytochrome P450 may be more toxic than the initial substances.[10] It is only through the proper balancing in the liver of all the steps of detoxification that a nontoxic substance is produced and the withdrawal symptoms are reduced. This is the advantage of a tailored nutritional approach to improving liver detoxification, because each of the liver's detoxification processes is normalized, resulting in improvement in the excretion of nontoxic substances.

Antioxidant nutrients, such as vitamins C, E, and carotene, are very important in minimizing damage to the body that might occur as a consequence of an increase in the rate of detoxification during drug or alcohol treatment. **The overall beneficial effects of the diet on the liver's detoxifying ability, therefore, are a result of the combined influence of the**

easily digested white rice protein concentrate, the energy-efficient dietary fat source of medium-chain triglycerides, easily-digested carbohydrates with a very low potential for fermentation in the gut to toxic substances (high-molecular-weight dextrins from rice), and the specific nutrients known to support the liver's effective detoxification processes, such as zinc, copper, manganese, iron, B-vitamins, and the antioxidant vitamins.

The most significant improvement in toxicity-related symptoms seen within the first 10 days of the diet included reductions in "tired eyes," "pain behind the eyes," headaches, digestive disturbances, morning pain and stiffness, and chronic respiratory complaints.

Conclusion

My colleagues and I concluded from this research that a specific nutrient-tailored diet can be very helpful in improving the potential for positive results in programs designed to treat alcohol and drug dependence. This 21-day diet, the first week of which is outlined in Table 3, has demonstrated its ability to support improved liver detoxification. **The remarkable difference between this dietary approach and traditional drug treatment to enhance liver function is that this diet improves both the first- and second-phase detoxification reactions, resulting in the excretion of fully detoxified substances.** It is very rewarding to witness the significant reduction of many of the chronic health complaints associated with toxicity during the 21-day diet intervention. This dietary approach is easily implemented and has demonstrated very high compliance, resulting in improved program success. As a result of this work, we suggest that all clinical management programs for substance abuse would experience improved success and reduced recidivism by implementing the proper nutrient-tailored diet intervention program.

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Questions Based on this Lesson

45. Which of the following statements is correct?

    A. Nutritional intervention is an underused tool in substance abuse management because nutrition's effects upon detoxification remains unclear today

    B. Drugs and their interactions may increase toxic reactions in the body since intermediate substances from cytochrome P450 are, in fact, less toxic than the initial substances

    C. A reduction in blood pressure is one significant improvement realized within the first 10 days of the nutritional diet outlined in this lesson

    D. An increased amout of hippuric acid excreted in a urine sample is indicative of a higher rate of detoxification

46. Which of the following nutrients or minerals is considered a "protector" in a detoxifying diet?

    A. Calcium

    B. Manganese

    C. Phosphorus

    D. Vitamin D

47. Oxygen free radicals

    A. are tertiary toxins

    B. are produced by the liver after detoxification enzymes are exposed to a substance of abuse

    C. can result in damage to the nervous system

    D. are neutralized only by intake of zinc, carotene, and Vitamin E

48. Substance abusers

    A. should consume dairy products daily if they are using a nutritional detoxifying diet

    B. rarely run the risk in altering their cognitive behavior

    C. may contract eczema due to an increased toxic burden caused by an alteration in their immune system

    D. tend to have stronger intestinal linings than non-substance abusers

DIRECTIONS IN REHABILITATION COUNSELING

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